2022

Providence

COMMUNITY HEALTH NEEDS ASSESSMENT

EXECUTIVE SUMMARY

Providence Medford Medical Center

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UNDERSTANDING AND RESPONDING TO COMMUNITY NEEDS

The Community Health Needs Assessment (CHNA) is an opportunity for Providence Medford Medical Center (PMMC) to engage with the community every three years to better understand community strengths and needs. At Providence, this process informs our partnerships, programs, and investments. Improving the health of our communities is foundational to our Mission and is a commitment deeply rooted in our heritage and purpose. Our Mission states, "As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable."

In Southern Oregon, PMMC collaborated with Asante to produce a comprehensive assessment of our communities' most pressing needs, share our findings with the broader public and develop new relationships leading to a healthier community. Before engaging in a collaborative process, both health systems agreed to a set of "principles of collaboration." Both organizations will:

- Collaborate to identify key health needs and issues in Jackson and Josephine counties
- Focus on community engagement and collaborative participation
- Avoid community partner burnout with respect to qualitative data collection through a collective approach to listening sessions and key informant interviews
- Commit to cash and/or in-kind resources from both parties, with resources used to develop a CHNA that satisfies regulatory requirements

Based on geographic location relative to other hospitals in the area and patient demographics, Jackson County is PMMC's primary service area with Josephine County considered as a secondary service area. Our 168-bed hospital provides an array of services including primary care, surgical services, obstetrics and gynecology, diagnostic imaging, pediatrics, intensive care, 24/7 emergency care and one of the most comprehensive rehabilitation programs in the region. The 2022 CHNA was approved by Providence's Southern Oregon Service Area Advisory Council on October 24th, 2022 and made publicly available on December 19th, 2022.

The collaborative CHNA report is available in Appendix 1.

GATHERING COMMUNITY HEALTH DATA AND COMMUNITY INPUT

Through a mixed-methods approach and using quantitative and qualitative data, the CHNA team collected information from the following sources: American Community Survey, Behavioral Risk Factor Surveillance System (BRFSS), Centers for Disease Control and Prevention (CDC), County Health Rankings & Roadmaps, Esri Updated Demographics, Oregon Health Authority, Oregon Student Wellness Survey, and the U.S. Census (such as public health data regarding health behaviors, morbidity and mortality, and hospital-level data).

We conducted five listening sessions with 68 individuals who are from diverse communities, have lower incomes, and/or are medically underserved. We conducted ten stakeholder interviews with 12 representatives from organizations that serve these populations, specifically seeking to gain a deeper understanding of community strengths and opportunities. In addition, we conducted a community health survey in English and Spanish that engaged 1,237 residents. Below is a short list of highlights from our quantitative and qualitative data collection:

- Strong community partnerships are present between nonprofits, health care organizations, school districts, faith-based organizations, community and civic groups, and social support organizations, all working together to address community needs.

- Stakeholders identified housing as a foundational need and discussed the importance of Housing First, meaning people first need to be safely and stably housed before they can address their physical and behavioral health needs.
- Nearly 34% of community health survey respondents reported needing counseling or mental health services within the last year.
- 44-48% of 11th grade students in Jackson and Josephine counties reported signs of depression in 2020.

While care was taken to select and gather data that would tell the story of both health systems' service areas, it is important to recognize the limitations and gaps in information that naturally occur. A full accounting of data limitations can be found starting on page 13 of the CHNA report. Complete information related to the CHNA methods and processes can be found on page 6 of the CHNA report.

Identifying collaborative Health Priorities

Through a collaborative process, Asante and PMMC used a Health Equity Framework and a modified Mobilizing for Action through Planning and Partnerships (MAPP) model to create the CHNA. The modified MAPP model is a strategic planning process that relies on collaborative partnership and includes five assessment components to inform planning: Population Health Status Assessment, Community Engagement, Internal Utilization Data, Community Strengths and Assets, and Prioritization Protocol. Through this collaborative model, the following priority areas were agreed upon: Homelessness and Housing Instability, Mental Health, Substance Use, Access to Health Care Services, Affordable Childcare and Preschools, Economic Insecurity and Chronic Conditions. For a complete description of significant health needs, see page 23. A list of potential resources to address these needs can be found at the end of each "key themes" section.

PROVIDENCE MEDFORD MEDICAL CENTER: 2022 PRIORITY NEEDS

Asante and PMMC identified a wide spectrum of significant health needs, some of which are most appropriately addressed by other community organizations. Providence's Southern Oregon Service Area Advisory Council reviewed the collaborative health priorities and associated data. Considering PMMC's unique capabilities, community partnerships and potential areas of community impact, we are committed to addressing the following priorities as aligned with the collaborative priority areas:

Mental Health and Substance Use Disorder: Focus on prevention and treatment, social isolation, and community building related to safe spaces and recreation. This priority area refers to the growing challenges of accessing care due to workforce shortages, a lack of culturally responsive care and affordability.

Health Related Social Needs: Focus on housing stability, navigation of supportive services, food insecurity and transportation. This priority area refers to the unmet social needs that exacerbate poor health and quality-of-life outcomes.

Economic Security: Focus on affordable childcare, education, and workforce development. This priority area affects nearly every aspect of a person's life and refers to the challenge of affording basic living expenses and obtaining affordable education.

Access to Care and Services: Focus on chronic disease management and prevention, oral health, and virtual care. This priority area refers to the lack of timely access to care and services due to physical, geographic, and systemic limitations, among others.

Three consistent cross-cutting themes surfaced during the assessment process and analysis, affecting all four priority areas:

- Racism, discrimination, and inclusion
- Culturally responsive care and services
- Trauma-informed care and services

PMMC will develop a three-year Community Health Improvement Plan (CHIP) to respond to these prioritized needs, in collaboration with community partners, to make the best use of resources, community strengths and capacity. The 2023-2025 CHIP will be approved and made publicly available no later than May 15th, 2023.

MEASURING OUR SUCCESS: RESULTS FROM THE 2019 CHNA AND 2020-2022 CHIP

This report evaluates the impact of the 2020-2022 CHIP. PMMC responded to community needs by making investments of direct funding, time, and resources to support internal and external programs dedicated to addressing the previously prioritized needs using evidence-based and leading practices. This summary highlights several community health initiatives across PMMC's service area. Written comments on the 2019 CHNA and 2020-2022 CHIP reports were collected in several ways and made widely available to the public via internet posts in December 2019 (CHNA) and May 2020 (CHIP), as well as through various channels with our community-based organization partners. Three methods were employed to collect public comments on the previous CHNA and CHIP:

- Visitors to Asante and Providence's websites were allowed to submit public comment via email to the appropriate community benefit teams.
- CHNA survey respondents were encouraged to follow links to both Asante and Providence's community benefit webpages where previous CHNAs and CHIPs are publicly accessible.
- Key informant surveys were conducted with professionals from different sectors including, but not limited to, health care, government, social services, and education. Full results from the key informant survey can be found in Appendix 2 of the full CHNA report.

The 2019 CHNA priorities were social determinants of health resulting from poverty and inequity, chronic health conditions, community mental health/ well-being and substance use disorders, and access to health services. The table below is a summary of the strategies and outcomes for each priority identified in PMMC's 2020-2022 CHIP.

Outcomes from the 2020-2022 CHIP

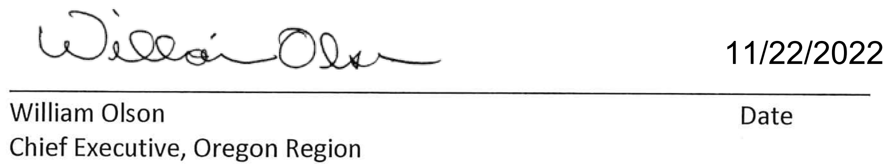
Priority Need	Program or Service Name	Program or Service Description	Results/Outcomes
Chronic Conditions	Providence Diabetes Prevention Program	Increase the number of Diabetes Prevention Program (DPP) cohorts to Jackson County residents	**Due to the COVID-19 pandemic, DPP cohorts were held virtually:** 2020 - 6 cohorts 2021 - 12 cohorts 2022 – 13 cohorts
	Addressing Diabetes in the Latinx Community	Partner with La Clinica to serve Latinx patients living with diabetes	**# of individuals served:** Jan-Mar 2022: 1,081 individuals
Access to Care/Oral Health	Medical Teams International Free Mobile Dental Clinics	Partner with Medical Teams International and St. Vincent de Paul to provide free emergency dental services to uninsured/underinsured community members	**# of clinics:** 2020 – 7 clinics 2021 – 4 clinics 2022 data not available
Behavioral Health/Substance Use Disorders	Providence Community Resource Desk	Connect Jackson County residents with behavioral health (BH) and substance use disorder (SUD) resources through the Providence Community Resource Desk	**# of individuals connected by CRD to BH and SUD resources:** 2020 – 59 individuals
	Integrated Behavioral Health Model	Partner with La Clinica to integrate behavioral health screening and treatment into a primary care model	**# of individuals served:** 2020 – 4,332 individuals
	Substance Use Disorder Treatment	Partner with Addictions Recovery Center to provide access to individuals seeking treatment for substance use and co-occurring mental health disorders	**# of individuals who received assessments:** 2020 – 1,733 individuals

	Therapy for Youth Experiencing Homelessness	Partner with the Maslow Project to provide therapy to adolescents in crisis	Grant concluded
	Wellness Program and Skill Building	Partner with Compass House to support community members living with mental health challenges as they build workplace skills, confidence, self-esteem, and healthy relationships	Grant concluded
	Suicide Prevention	Partner with the United Way to prevent suicide through three community-based efforts focused on mental wellness and removing stigma	Grant concluded
Social Determinants of Health and Well-being – Housing	Chronically Homeless Outreach Partnership	Partner with the City of Medford to provide transitional housing and case management services to individuals experiencing chronic homelessness	**# of individuals served:** 2020 – 14 individuals (this is less than expected due to the COVID-19 pandemic)
	Kelly Shelter	Partner with Rogue Retreat to provide year-round emergency shelter to individuals experiencing homelessness	**# of individuals served**: 2020 – 380 individuals
	Project Turnkey	Partner with the City of Medford to provide temporary housing and low-level support for individuals experiencing homelessness post hospital discharge	**# of rooms fully renovated to ADA standards:** 2021 – 4 rooms
	Rent and Utility Assistance	Partner with St. Vincent de Paul to prevent homelessness by providing rent and utility assistance	**# of persons served:** Jan-June 2021 – 40 persons
	Urban Campground	Partner with Rogue Retreat to provide temporary shelter and case management services to individuals experiencing homelessness	**# of individuals served:** 2021 – 1,025 individuals

	Capacity Building	Support Rogue Retreat to increase efficiency and capacity to serve more community members who are experiencing homelessness	Grant concluded
	Emergency Transitional Housing	Partner with ACCESS to provide emergency transitional housing to vulnerable unsheltered individuals and families	Grant concluded
Social Determinants of Health and Well-being – Food Insecurity	Providence Community Resource Desk	Partner with ACCESS to provide resources to food insecure households through the Providence Community Resource Desk	**# of individuals connected with food resources:** 2020 – 113 individuals
	Farm to Families Produce Box Program	Partner with Rogue Valley Farm to School to provide food boxes, fresh produce, and pantry staples to families in the Phoenix/Talent School District	**# of households receiving weekly produce boxes:** 2021 – 150-200 households for 12 weeks

2022 CHNA Governance Approval

Chris Pizzi — Date: 11/10/22
Chief Executive, Southern Oregon Service Area

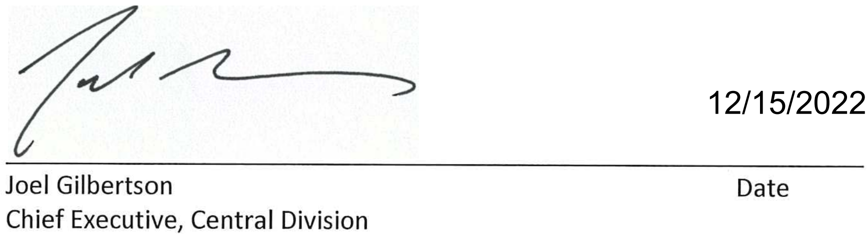


11/22/2022

William Olson — Date
Chief Executive, Oregon Region

11/22/2022

Louis Libby M.D. — Date
Chair, Oregon Community Ministry Board



12/15/2022

Joel Gilbertson — Date
Chief Executive, Central Division

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To request a copy free of charge, provide comments, or view electronic copies of current and previous Community Health Needs Assessments, please email CHI@providence.org.

Appendices

APPENDIX 1. 2022 ASANTE AND PROVIDENCE COMMUNITY HEALTH NEEDS ASSESSMENT

2022 Community Health Needs Assessment

Jackson and Josephine counties

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INTRODUCTION

Background

OVERVIEW OF THE HOSPITAL PARTNERSHIP

Asante and Providence Health & Services (Providence) are two not-for-profit health systems dedicated to creating health care access for everyone and improving health outcomes for the communities we serve. Striving to treat each person with compassion and dignity, Asante and Providence each operate a network of hospitals and acute care clinics spanning Jackson and Josephine counties.

Asante's health system in the region includes:

- Asante Ashland Community Hospital in Ashland
- Asante Rogue Regional Medical Center in Medford
- Asante Three Rivers Medical Center in Grants Pass
- Asante Physician Partners clinics throughout Jackson and Josephine counties

Providence Health & Services system in the region includes:

- Providence Medford Medical Center in Medford
- Providence Urgent Care in Medford and Central Point
- Providence Medical Group South throughout Jackson County

The goal of the Asante and Providence partnership is to produce a comprehensive assessment of our communities' most pressing needs, share our findings with the broader public, and develop new relationships leading to a healthier community.

This 2022 community health needs assessment (CHNA) represents the first iteration conducted exclusively as a partnership between Asante and Providence. Before engaging in a collaborative process, a set of Principles of Collaboration were agreed to:

- Collaborate to identify key health needs and issues in Jackson and Josephine counties.
- Focus on community engagement and collaborative participation.
- Avoid community partner burnout with respect to qualitative data collection through a collective approach to listening sessions and key informant interviews.
- Commitments of cash and/or in-kind resources from both parties. Committed resources will be used to develop a CHNA that satisfies regulatory requirements.

PURPOSE AND SCOPE OF 2022 ASSESSMENT

In collaboration, Asante and Providence conducted a community health needs assessment in Jackson and Josephine counties to serve as the guiding document when developing improvement strategies and making targeted investments in the community. Establishing a shared understanding of community needs serves as the foundation for developing a community health improvement plan (CHIP) for each individual hospital. In addition, both Asante and Providence are required by section 501(r) of the

Internal Revenue Service Code, as tax-exempt 501(c)3 organizations that operate one or more hospital facilities, to conduct a CHNA at least once every three years for each hospital.

Our Commitment to Community

Asante and Providence dedicate resources to improving the health and quality of life for the communities we serve. During 2021, Asante and Providence provided $113,000,000 and $64,000,000, respectively, in Community Benefit[1] in response to unmet needs and to improve the health and well-being of those our health systems serve across Jackson and Josephine counties.

Asante and Providence further demonstrate organizational commitment to community health through the allocation of staff time, financial resources, participation, and collaboration to address community identified needs. The staff dedicated to working on hospital community benefit are responsible for ensuring the compliance of State and Federal 501(r) requirements. They also support community and hospital leaders, physicians, and others who work together to plan and implement the resulting community health improvement plan (CHIP) for each hospital.

[1] Per Oregon State reporting

CHNA FRAMEWORK AND PROCESS

Overview

The CHNA process is based on the understanding that health and wellness are influenced by factors within our communities, not only within medical facilities. In gathering information on the communities served by Asante and Providence, we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, and health behaviors. Additionally, we invited key stakeholders and community members to provide additional context to the quantitative data through qualitative data in the form of interviews and listening sessions. As often as possible, equity is at the forefront of our conversations and presentation of the data, which often have biases based on collection methodology.

In addition, we recognize there are often geographic areas where the conditions for supporting health are substantially poorer than nearby areas. Whenever possible and reliable, data are reported at the zip code or census tract level. These smaller geographic areas allow us to better understand the neighborhood level needs of our communities and better address inequities within and across communities. For example, we reviewed data from the American Community Survey and County Health Rankings & Roadmaps. In addition, Providence includes hospital utilization data to identify disparities in utilization by income and insurance, geography, and race/ethnicity when reliably collected.

Approach and Methods

The following section describes the assessment framework used for community engagement, data collection, and analysis.

HEALTH EQUITY FRAMEWORK

Asante and Providence acknowledge that all people do not have equal opportunities and access to living their fullest, healthiest lives due to systems of oppression and inequities. We are committed to ensuring health equity for all by addressing the underlying causes of racial and economic inequities and health disparities. To improve the health of our communities, we believe we must address not only the clinical care factors that determine a person's length and quality of life, but also the social and economic factors, the physical environment, and the health behaviors that all play an active role in determining health outcomes (see Figure 1[2]).

[2] Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2013)

The CHNA is an important tool we use to better understand health disparities and inequities within the communities we serve, as well as the community strengths and assets (see Figure 2 for definition of terms[3]). Through the literature and our community partners, we know that racism and discrimination have detrimental effects on community health and well-being. We recognize that racism and discrimination prevent equitable access to opportunities and the ability of all community members to thrive. We name racism as contributing to the inequitable access to all the determinants of health that help people live their best lives, such as safe housing, nutritious food, responsive health care, and more.

Figure 1. Factors contributing to overall health and well-being

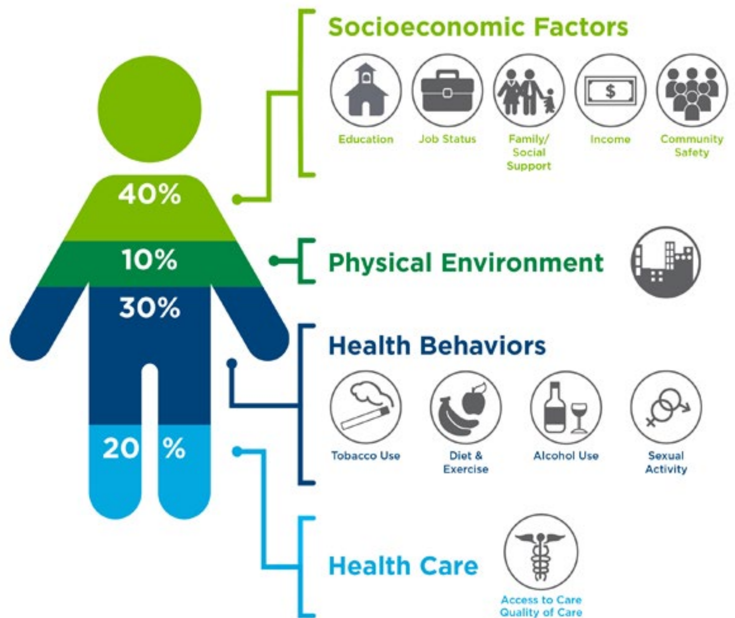

Figure 2. Definitions of key terms

Health Equity

A principle meaning that "everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care. For the purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups." (Braverman, et al., 2017)

Health Disparities

Preventable differences in the burden of disease or health outcomes as a result of systemic inequities.

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[3] Braverman P, Arkin E, Orleans T, Proctor D, and Plough A. *What is Health Equity? And what Difference Does a Definition Make?* Princeton, NJ: Robert Wood Johnson Foundation, 2017.

To ensure that equity is foundational to our CHNA, we developed an equity framework that outlines the best practices that each of our hospitals will implement when completing a CHNA. These practices include, but are not limited to the following:

Approach

Explicitly name our commitment to equity.

Take an asset-based approach, highlighting community strengths.

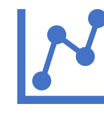
Use people first and non-stigmatizing language.

Community Engagement

Actively seek input from the communities we serve using multiple methods.

Implement equitable practices for community participation.

Report findings back to communities.



Quantitative Data

Report data at the block group level to address masking of needs at county level.

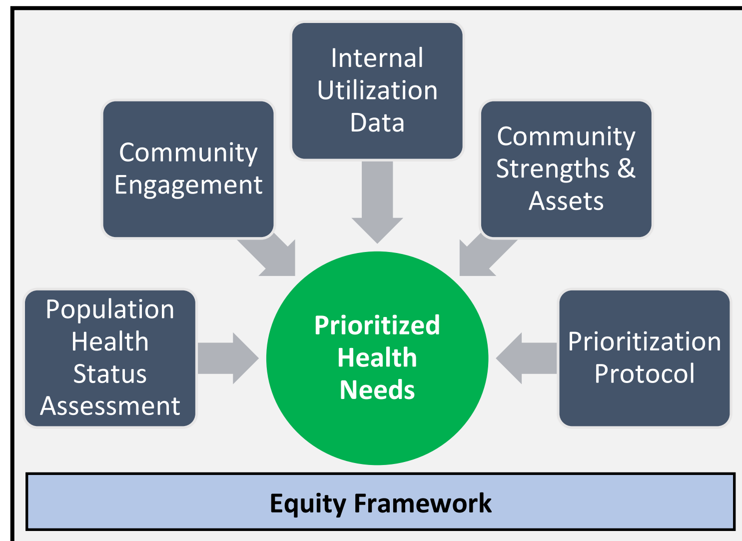
Disaggregate data when responsible and appropriate.

Acknowledge inherent bias in data and screening tools.

MODIFIED MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS (MAPP) FRAMEWORK

Asante and Providence used a modified version of the Mobilizing for Action through Planning and Partnerships (MAPP) model as a framework to guide the CHNA process. Using a mixed-methods approach allowed us to consider several key elements necessary to determine prioritized health needs including:

- Population health data
- Community engagement
- Utilization data
- Community strengths & assets
- Prioritization protocol



DATA COLLECTION AND ANALYSIS METHODS

Stakeholder Interviews and Community Listening Sessions

Providence and Asante contracted with the Rede Group to conduct stakeholder interviews and community listening sessions. Listening to and engaging with the people who live and work in the community is a crucial component of the CHNA, as these individuals have firsthand knowledge of the needs and strengths of the community. The Rede Group conducted 10 stakeholder interviews including 12 participants, people who are invested in the well-being of the community and have first-hand

knowledge of community needs and strengths. They also conducted 5 listening sessions with a total of 68 community members. The goal of the interviews and listening sessions was to identify what needs are currently not being met in the community and what assets could be leveraged to address these needs.

The Rede Group conducted stakeholder interviews and listening sessions in January and February 2022. Stakeholders were selected based on their knowledge of the community and engagement in work that directly serves people who are economically poor and vulnerable. Providence and Asante aimed to engage stakeholders from social service agencies, health care, education, housing, and government, among others, to ensure a wide range of perspectives. Included in the interviews was the Program Manager for Communicable Disease and Epidemiology Data and Performance from Jackson County Public Health.

Full details on the protocols, findings, and attendees are available in Appendix 1.

Community Health Survey

The community health survey was open from February 7th to March 20th, distributed in both paper and electronic formats, and available in English and Spanish. The survey captured key information on health and lifestyle factors, community needs, and barriers to accessing health and social services in Jackson and Josephine counties. Out of 1,261 English survey responses, 1,189 were taken by respondents within the primary service areas and all 62 Spanish survey responses were taken within the primary service areas. The survey was conducted electively and while efforts were made to engage the diverse populations of our primary service area, survey results are not representative of demographics in the general population. The tables below highlight demographic information for survey respondents.

Figure 1. Respondents by County, English and Spanish Survey

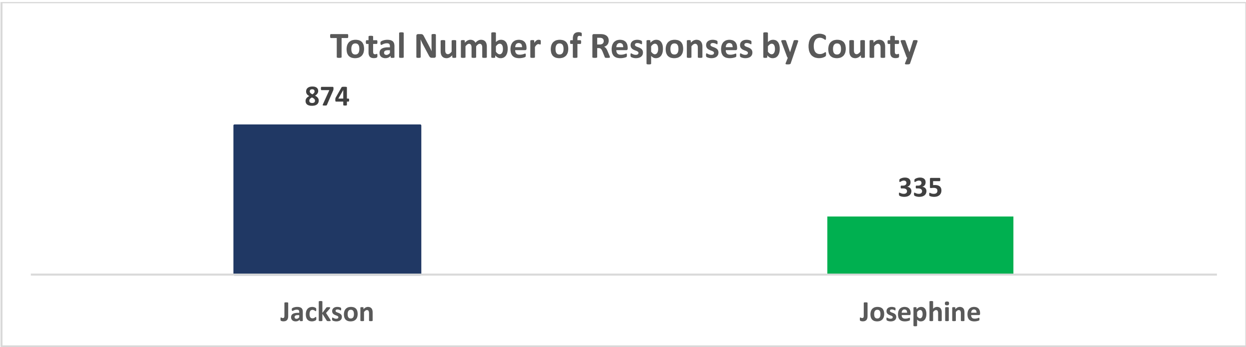


Table 1. Respondents by County, English and Spanish Survey

	English Survey		Spanish Survey	
County	Respondents	Percentage	Respondents	Percentage
Jackson	819	70.6%	55	96.5%
Josephine	333	28.7%	2	3.5%
Coos, Douglas, Klamath, Lane, Marion, Wasco	8	0.7%	0	0%

Skipped Question	29	-	5	-
Total Respondents	1160	-	57	-

The largest age group of respondents was between the ages of 35-54 (39.9%). The second largest age group of respondents was age 65+ (24.1%).

Figure 2. Respondents by Age Group, English and Spanish Survey

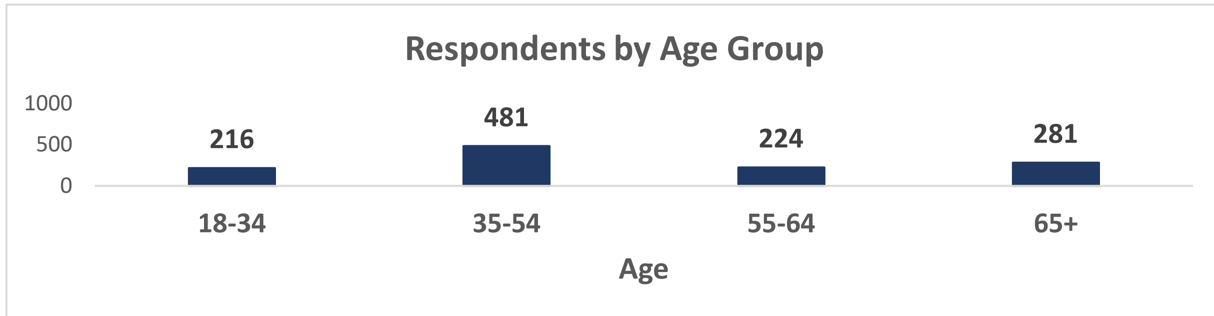


Table 2. Respondents by Age Group, English and Spanish Survey

Age Range	English Survey		Spanish Survey	
	Count	Percentage	Count	Percentage
Under 18	-	-	1	2.3%
18-34	200	17.3%	16	36.4%
35-54	462	39.9%	19	43.2%
55-64	218	18.8%	6	13.6%
65+	279	24.1%	2	4.5%
Skipped Question	30	-	18	-
Total Respondents	1159	-	44	-

The largest group of respondents by gender was female (82.3%). The high percentage of female survey respondents differs from the percentage of females in the general population (51.1%).

Table 3. Respondents by Gender

Gender Identity	English Survey		Spanish Survey	
	Count	Percentage	Count	Percentage
Female	970	82.3%	50	80.7%
Male	182	15.4%	5	8.1%
Transgender	8	0.7%	0	0%
Gender non-binary	-	-	1	1.6%
Gender non-conforming	3	0.3%	0	0%
Choose not to answer	14	1.2%	1	1.6%
Other	2	0.2%	1	1.6%
Skipped Question	10	-	4	-
Total Responses	1179	-	58	-

The largest group of respondents by race was White for both the English and Spanish language surveys (85.4% and 63.4%, respectively). This question allowed respondents to “check all that apply” resulting in a large variation of responses. A variation in responses highlights the importance of community members having the option to self-identify as accurately as possible.

Table 4. Respondents by Race

Race	English Survey		Spanish Survey	
	Count	Percentage	Count	Percentage
American Indian or Alaska Native	10	0.8%	6	9.7%
Asian	24	2.0%	2	3.2%
Black or African American	24	2.0%	-	-
Black or African American/Asian	1	0.1%	-	-
Do not know, not sure	6	0.5%	5	8.1%
Middle Eastern/North African	1	0.1%	-	-
Native Hawaiian or other Pacific Islander	5	0.4%	5	8.1%
Prefer not to answer	57	4.8%	8	12.9%
White	1008	85.4%	30	48.4%
White/American Indian or Alaska Native	22	1.9%	-	-
White/American Indian or Alaska Native/Do not know, not sure	1	0.1%	-	-
White/Asian	7	0.6%	0	0%
White/Asian/American Indian or Alaska Native	1	0.1%	-	-
White/Black or African American	2	0.2%	-	-
White/Black or African American/American Indian or Alaska Native	3	0.3%	-	-
White/Black or African American/Native Hawaiian or Other Pacific Islander	1	0.1%	-	-
White/Do not know, not sure	2	0.2%	-	-
White/Middle Eastern/North African	1	0.1%	-	-
White/Native Hawaiian or Other Pacific Islander	2	0.2%	-	-
White/Prefer Not to Answer	3	0.3%	-	-
Skipped Question	7	-	7	-
Total Responses	1181	100%	55	-

Table 5. Respondents by Ethnicity

Latin/Hispanic/Spanish Origin	English Survey		Spanish Survey	
	Count	Percentage	Count	Percentage
No	1049	91.46%	3	4.8%
Yes	98	8.54%	56	90.3%
Skipped	42	-	2	-
Total Responses	1147	-	46	-

The largest group of respondents by sexual orientation was Heterosexual or Straight for both the English and Spanish surveys (78.4% and 55.0%, respectively). The second largest group chose not to answer this question. The higher-than-average prevalence of 'asexual' identifications among both English and Spanish survey respondents suggests individuals may have been interpreting 'asexual' to be interchangeable with 'abstinent,' 'unpartnered,' or 'celibate.'

Table 6. Respondents by Sexual Orientation

Sexual Orientation	English Survey		Spanish Survey	
	Count	Percentage	Count	Percentage
Asexual	53	4.5%	6	9.7%
Bisexual	64	5.5%	2	3.2%
Gay	11	0.9%	-	-
Heterosexual or straight	919	78.4%	34	54.8%
Lesbian	15	1.3%	-	-
Pansexual	6	0.5%	-	-
Queer	6	0.5%	-	-
Choose not to answer	92	7.8%	10	16.1%
Other	6	0.5%	1	1.6%
Skipped Question	17	-	9	-
Total Responses	1172	-	53	-

Nearly 50% of English survey respondents and 90.5% of Spanish survey respondents had a household income under $60,000. In 2019, the median household income in Jackson County, Josephine County, and Oregon was $53,571, $45,595, and $62,818, respectively.

Table 7. Respondents by Household Income

Household Income	English Survey		Spanish Survey	
	Count	Percentage	Count	Percentage
Less than $20,000	162	14.3%	14	22.6%
$20,001 to $40,000	184	16.3%	31	50.0%
$40,001 to $60,000	204	18.1%	7	11.3%
$60,001 to $80,000	159	14.1%	1	1.6%
$80,001 to $100,000	168	14.9%	1	1.6%
$100,000 and over	252	22.3%	2	3.2%
Skipped Question	60	-	6	-
Total Responses	1129	100%	56	-

Review of Secondary Data

This CHNA incorporated quantitative data on health conditions, health behaviors, and social determinants of health. Data was pulled from local, state, and national levels to identify how health trends have changed over time. Data sources in this CHNA include:

- American Community Survey
- Behavioral Risk Factor Surveillance System (BRFSS)
- Centers for Disease Control and Prevention
- County Health Rankings & Roadmaps
- ESRi Updated Demographics
- Oregon Health Authority
- Student Wellness Survey (2020)
- U.S. Census Bureau

Data Limitations and Information Gaps

While care was taken to select and gather data that would tell the story of Asante and Providence's service areas, it is important to recognize the limitations and gaps in information that naturally occur, including the following:

- Not all desired data were readily available, so sometimes we had to rely on tangential or proxy measures or not have any data at all. For example, there is little community-level data on the incidence of mental health or substance use.
- While most indicators are relatively consistent from year to year, other indicators are changing quickly (such as percentage of people uninsured) and the most recent data available are not a good reflection of the current state.
- Reporting data at the county level can mask inequities within communities. This can also be true when reporting data by race, which can mask what is happening within racial and ethnic subgroups. Therefore, when appropriate and available, we disaggregated the data by geography and race.
- Data that are gathered through interviews and surveys may be biased depending on who is willing to respond to the questions and whether they are representative of the population as a whole.
- The accuracy of data gathered through interviews and surveys depends on how consistently the questions are interpreted across all respondents and how honest people are in providing their answers.
- Due to the COVID-19 pandemic and burnout experienced by community-based organizations, listening sessions were conducted virtually which limited the number of people able to participate and created technology challenges for some participants.
- Spanish-language surveys were difficult to collect. Our community partners reported that Spanish-speaking families were often less inclined to respond due to cultural differences in

disclosing private information. Additionally, efforts to engage Spanish speakers through social media advertisements were not effective, with only a handful of respondents completing the survey after engaging with the link. The majority of Spanish respondents completed paper surveys through a community partner.

- Social media advertising, combined with a sweepstakes component for completion, along with direct invitations to local professionals, may have inadvertently recruited a more affluent demographic than intended, resulting in skewed survey results. 20% of English respondents reported an income more than $100,000, with 51% reporting incomes over $60,000. Paper responses collected through community partners revealed a prevalence of incomes between $0 and no higher than $40,000.
- While efforts were made to actively engage a broad cross-section of the community, demographic information demonstrates the majority of responses were garnered from White, middle-aged women.

Process for Gathering Comments on Previous CHNA and Summary of Comments Received

Written comments were solicited on the 2019 CHNA and 2020-2022 CHIP reports in several ways, which were made widely available to the public via posting on the internet in December 2019 (CHNA) and May 2020 (CHIP), as well as through various channels with our community-based organization partners. There were three methods employed to collect public comments on the previous CHNA and CHIP:

- Allowing visitors to Asante and Providence's websites to submit public comment via email to the appropriate community benefit teams.
- Encouraging respondents of the CHNA Survey to follow links to both Asante and Providence's community benefit webpages where previous CHNAs and CHIPs are publicly accessible.
- Conducting key informant surveys with professionals from different sectors including, but not limited to, health care, government, social services, and education. Results from the key informant surveys are below.

Nineteen key informants from a variety of community organizations provided an overall rating on both Asante Rogue Regional Medical Center (ARRMC) and Providence Medford Medical Center's (PMMC) efforts to address priorities identified in both organization's 2019-2021 Community Health Improvement Plans (CHIP). The overall ratings for each priority are summarized in the tables below. Full results from the key informant survey can be found in Appendix 2.

Table 1. Key Informant Ratings on How Asante Rogue Regional Medical Center Is Addressing Their CHIP Priorities

2020-2022 CHIP Priorities	Poor	Fair	Good	Very Good	Excellent
Access to Healthcare	0%	5.3%	47.4%	31.6%	10.5%
Substance Abuse	10.5%	36.8%	36.8%	15.8%	0%
Mental Health	5.3%	31.6%	31.6%	26.3%	5.3%
Heart Disease and Stroke	0%	0%	15.8%	47.4%	31.6%
Infant Health	0%	0%	47.4%	42.1%	10.5%

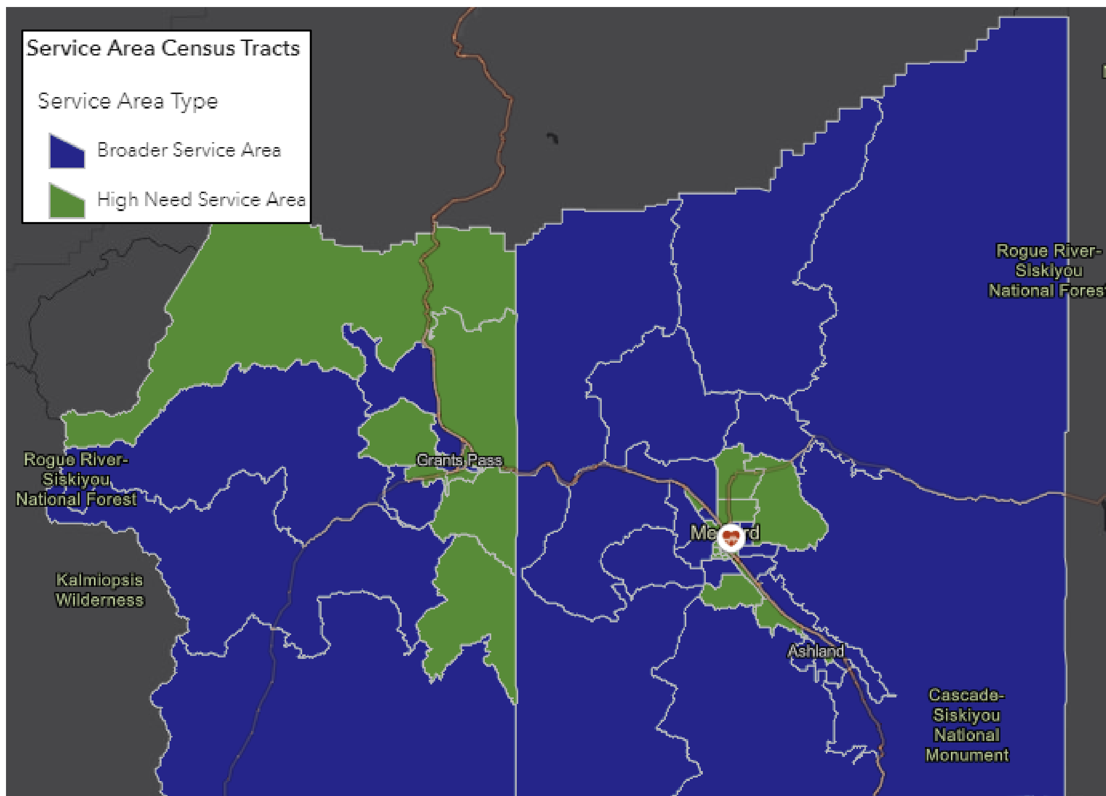
Table 2. Key Informant Ratings on How Providence Medford Medical Center Is Addressing Their CHIP Priorities

2020-2022 CHIP Priorities	Poor	Fair	Good	Very Good	Excellent
Social Determinants of Health	0%	5.3%	79.0%	10.5%	5.26%
Chronic Conditions	0%	0%	73.7%	21.1%	5.26%
Mental Health/Well-being and Substance Use Disorder	5.3%	31.6%	42.1%	15.8%	5.3%
Access to Care	0%	0%	63.2%	26.3%	10.5%

REGIONAL SNAPSHOT – OUR COMMUNITY

Hospital Service Area and Community Served

Asante and Providence Medford Medical Center provide care to Jackson and Josephine Counties, which includes a population of approximately 308,903 people across both counties. Based on the availability of data, geographic access to these facilities and primary care, and other hospitals in neighboring counties, Jackson and Josephine Counties serve as the boundary for the hospital's primary and secondary service areas. See map below for further detail, including communities identified as higher need. There are 80 census tracts in the high need service area and 119 in the broader service area.



Community Demographics

The tables and graphs below provide basic demographic and socioeconomic information about the service area and how the high need area compares to the broader service area. The high need area includes census tracts identified based upon lower life expectancy at birth, a lower percent of the population with at least a high school diploma, more households which are linguistically isolated and more households at or below 200% of the Federal Poverty Level (FPL) compared to county averages. For reference, in 2019, 200% FPL represents an annual household income of $51,500 or less for a family of four.

Providence developed a dashboard that maps each CHNA indicator at the census tract level for Jackson and Josephine Counties. Click here to access the dashboard.

The following population demographics are from Esri Updated Demographics which provides annually updated U.S. Demographic data for current year demographics and socioeconomic characteristics. Population data uses 2021 current-year Esri Updated Demographics. More information on Esri Updated Demographics including its methodology can be found here. Additional quantitative data can be found in Appendix 3.

Table 1. Total Population and Percent Change, by State and County, 2012-2016 and 2017-2021

	2016	2021	% Change
Oregon	3,982,267	4,246,155	6.6% ⬆
Jackson County	210,916	219,969	4.3% ⬆
Josephine County	84,063	88,934	5.8% ⬆

Table 2. Population by Sex

Indicator	Jackson County	Josephine County	Broader Service Area	High Need Service Area
Female Population	112,502	45,437	74,059	38,443
Male Population	107,467	43,497	69,952	37,515
% Female Population	51.1%	51.1%	40.6%	30.4%
% Male Population	48.9%	48.9%	38.3%	29.7%

Figure 1. Age Distribution, by County, 2021

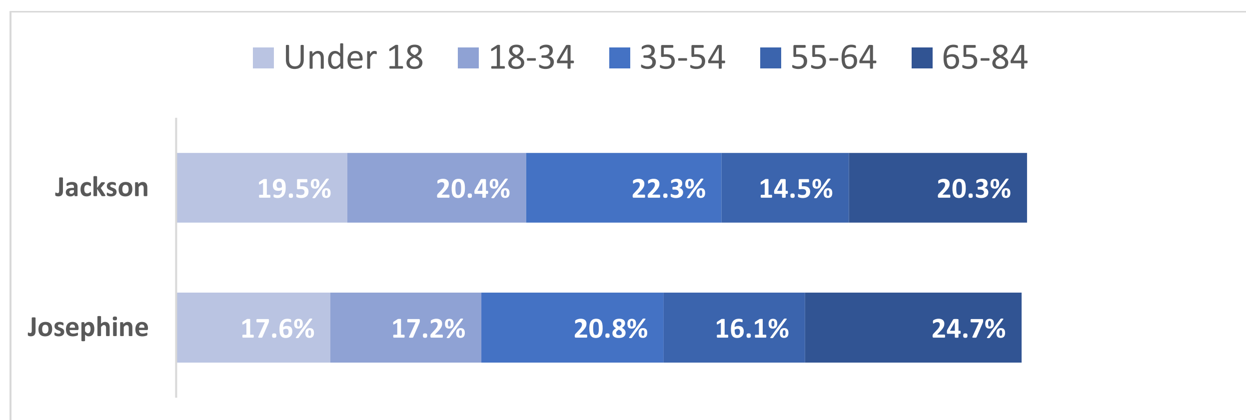


Figure 2. Population by Race and Ethnicity

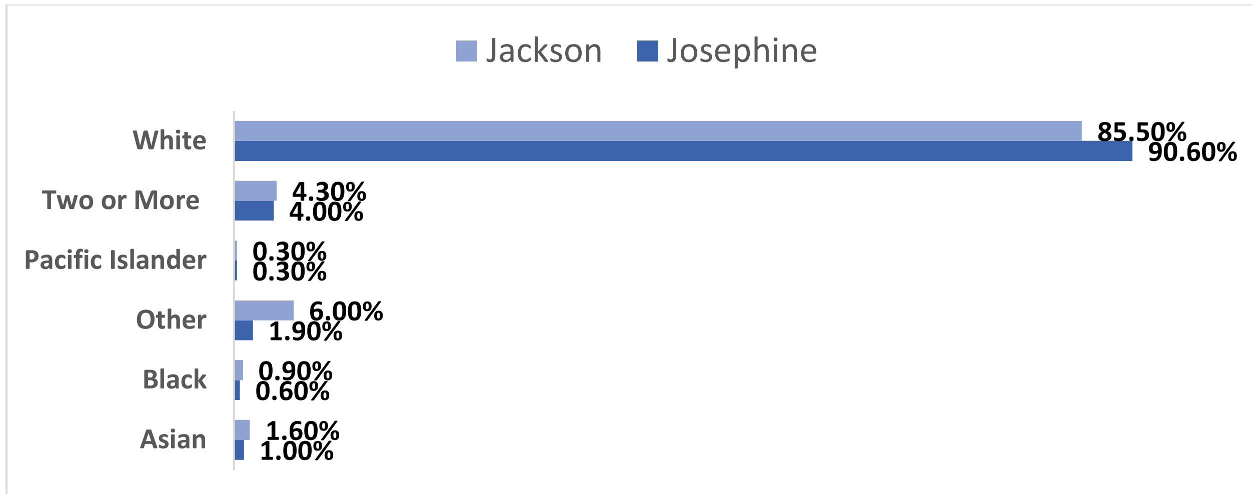


Figure 3. Population by Hispanic Ethnicity

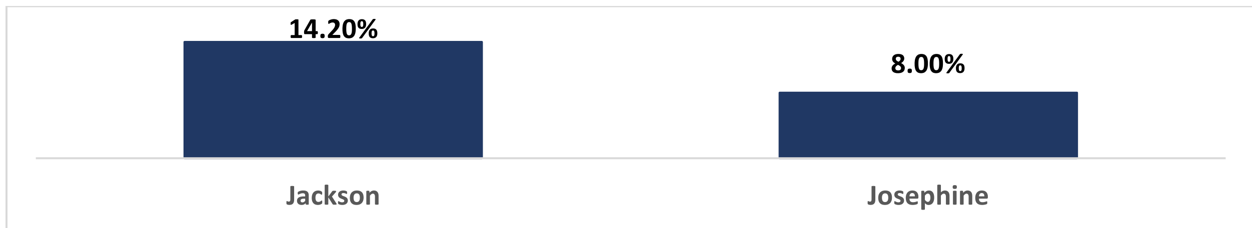


Table 3. Median Income

Indicator	Oregon	Jackson County	Josephine County	Broader Service Area	High Need Service Area
Median Income Data Source: American Community Survey Year: 2019	$62,818	$53,571	$45,595	$58,285	$45,020

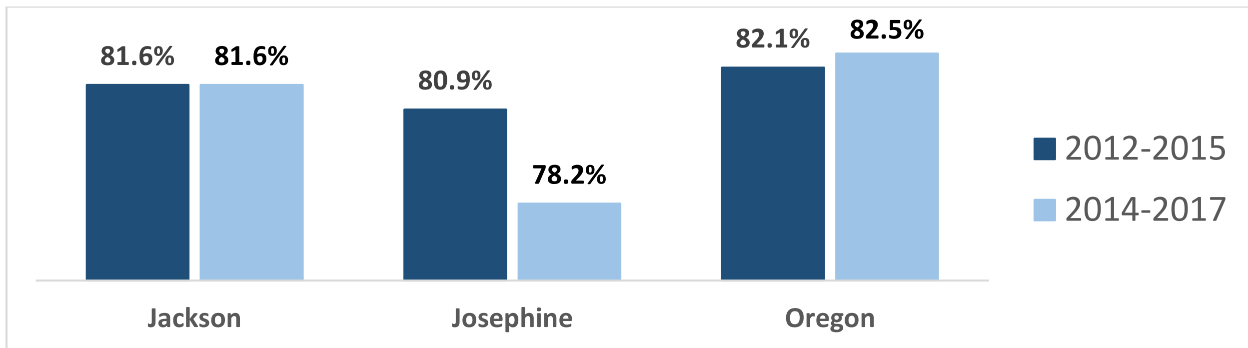
Table 4. Severe Housing Cost Burden

Indicator	Oregon	Jackson County	Josephine County	Broader Service Area	High Need Service Area
Percent of Renter Households with Severe Housing Cost Burden Data Source: American Community Survey Year: Estimates based on 2013 – 2017 data	24%	26.8%	27.6%	24.6%	26.6%

GENERAL HEALTH STATUS AND MORTALITY

According to BRFSS, the nation's premier system of health-related data collection on risk behaviors, chronic health conditions, and use of preventive services, the age-adjusted percent adults who reported general health status as good or very good or excellent varies by nation, state, and county. Over 80% of adults in Jackson County and statewide reported their general health status as good, very good, or excellent compared to just over 78% of adults in Josephine County in years 2014-2017. Across the two time periods reviewed, adults in Josephine County reported a decrease in general health status while adults in Oregon reported an increase.

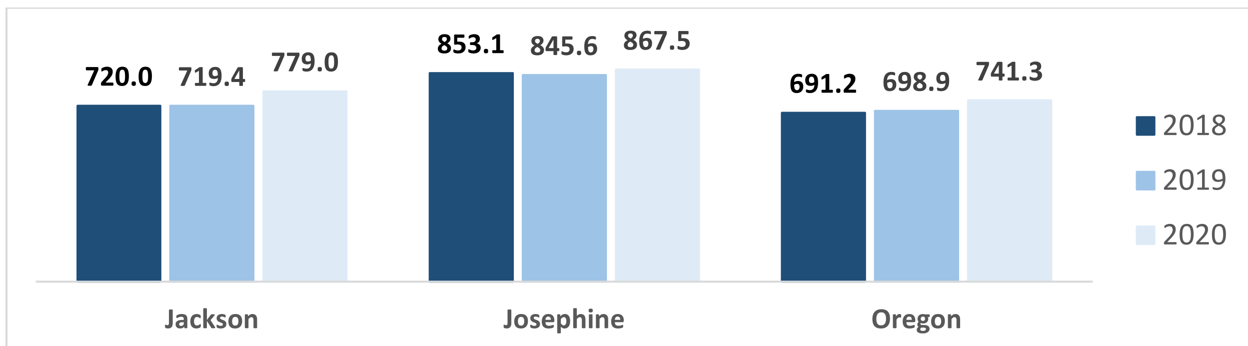
Figure 4. Age-Adjusted Percent Adults Reported General Health Status as Good or Very Good or Excellent, by State and County, 2014-2017



DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2017; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2014-2017

The mortality rates for Jackson and Josephine Counties were higher than for Oregon in each year, 2018-2020. Jackson and Josephine Counties and Oregon saw a decrease from 2018 to 2019 and all three saw an increase in mortality in 2020.

Figure 5. Age-Adjusted Overall Mortality Rate Per 100,000 Population, by State and County, 2018-2020



DATA SOURCE: Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2017-2020

In 2020, the top three leading causes of mortality (cancer, heart disease, and accidents) were the same in Jackson and Josephine Counties and Oregon. The fourth leading cause of mortality in both Jackson and Josephine Counties was chronic lower respiratory disease, and cerebrovascular diseases in Oregon. The fifth leading cause of mortality in Jackson County and Oregon was Alzheimer Disease, and cerebrovascular diseases in Josephine County.

Table 5. Top Five Leading Causes of Mortality, Age-Adjusted Rates Per 100,000 Population, 2020

Rank	Jackson County	Josephine County	Oregon
1	Cancer 141.9	Cancer 178.7	Cancer 145.9
2	Heart Disease 120.5	Heart Disease 137.0	Heart Disease 134.0
3	Accidents 45.4	Accidents 61.6	Accidents 52.2
4	Chronic Lower Respiratory Disease 40.4	Chronic Lower Respiratory Disease 53.3	Cerebrovascular Diseases 40.5
5	Alzheimer Disease 39.0	Cerebrovascular Diseases 34.8	Alzheimer Disease 37.0

DATA SOURCE: Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2020

HEALTH PROFESSIONAL SHORTAGE AREA

The Federal Health Resources and Services Administration (HRSA) designates Health Professional Shortage Areas (HPSA) as areas with a shortage of primary medical care, dental care, or mental health providers. They are designated according to geography (i.e., service area), demographics (i.e., low-income population), or institutions (i.e., comprehensive health centers). Jackson and Josephine Counties are both located in a HPSA. See Appendix 3 for additional details on HPSA and Medically Underserved Areas and Medically Underserved Populations.

COMMUNITY INPUT

To better understand the unique perspectives, opinions, experiences, and knowledge of community members, the Rede Group, on behalf of Asante and Providence, conducted 10 stakeholder interviews including 12 participants, and five listening sessions with a total of 68 community members. All community input was collected in January and February 2022. Below is a high-level summary of the findings of these sessions; full details on the protocols, findings, challenges, and attendees are available in Appendix 1.

Vision for a Healthy Community

Listening session participants were asked to describe their vision of a healthy community. This question is important for understanding what matters to community members and how they define health and wellness for themselves, their families, and their communities. The primary theme shared was "social connection and support," and participants noted this has been especially important during challenging times, such as the Almeda and Obenchain fires that impacted the community in 2020 and the COVID-19 pandemic. The following is a list of all the themes that emerged:

- Social connection and support
- Resources to meet people's needs
- Diversity and inclusion
- Education and employment opportunities
- Affordable housing and economic security
- Safety

Community Strengths

While a CHNA is primarily used to identify gaps in services and challenges in the community, we want to ensure that we highlight and leverage the community strengths that already exist, including the following identified for Jackson and Josephine counties:

STRONG COMMUNITY PARTNERSHIPS TO MEET NEEDS

The primary strength shared was "strong community partnerships." These strong partnerships are between nonprofits, health care, school districts, faith-based organizations, community and civic groups, and social support organizations, all working together to address community needs. Stakeholders described strong reliance on community partnerships that have been important in times of crisis, particularly in response to COVID-19 and wildfires. These partnerships have allowed emergency response activities to deploy quickly.

ROBUST NETWORK OF HEALTH-RELATED SERVICES AND RESOURCES

Stakeholders identified the variety of health care and social service organizations as a community strength. Specifically, they noted a variety of health care and behavioral health resources that support

accessing care. The Coordinated Care Organizations (AllCare, Jackson Care Connect) were noted to offer programs and resources to address social determinants of health.

RESILIENT AND ENGAGED COMMUNITY MEMBERS

Stakeholders emphasized community resilience as a strength, particularly after the wildfires in 2020. They noted that the community came together to rebuild and collaborate to address the resulting needs. They described an energetic community, willing to pull together to respond in times of challenge.

Community Needs

Listening session participants discussed a variety of needs, but the two most common were **access to health care services** and **homelessness and housing instability**. Access to health care services was the most common need mentioned and included needing more affordable medical care, more health care providers to ease access, and more financial assistance. Participants shared a need for more affordable housing, particularly after the Almeda fire in 2020, which destroyed thousands of homes in Jackson County, as well as more transitional and supportive housing. They emphasized concern for neighbors experiencing homelessness and shared a need for more resources, hygiene facilities and restrooms, and mental health support. Other needs discussed in detail included **mental health, substance use, economic insecurity, easy access to and coordination of community resources, childcare, safe and accessible parks and recreation, and community building and efforts to address systemic racism.** Additional detail can be found in the Key Themes section below.

Challenges in Obtaining Community Input

While video conferencing does facilitate information sharing, there were challenges creating the level of dialogue that would take place in person. Additionally, due to many community organizations engaging in COVID-19 response, some organizations had limited capacity and were not able to participate in interviews.

KEY THEMES

This Key Themes section describes the highest priority needs determined through an analysis of qualitative data (key stakeholder interviews, listening sessions), community health survey data, and publicly available population-level data. The key themes below are listed in order of highest priority as identified by community participants.

Homelessness and Housing Instability

IMPORTANCE AND CONNECTION TO OTHER HEALTH ISSUES

County Health Rankings and Roadmaps explains the link between health and housing in the following way: "There is a strong and growing evidence base linking stable and affordable housing to health. As housing costs have outpaced local incomes, households not only struggle to acquire and maintain adequate shelter, but also face difficult trade-offs in meeting other basic needs. When the majority of a paycheck goes toward the rent or mortgage, it makes it hard to afford doctor visits, healthy foods, utility bills, and reliable transportation to work or school. This can, in turn, lead to increased stress levels and emotional strain."[4]

KEY FINDINGS

Qualitative Data

Homelessness and housing instability were the top issues raised from listening sessions and stakeholder interview discussions. Stakeholder interviews described the impact of the 2020 Almeda and South Obenchain fires, which worsened the availability and affordability of housing, noting the loss of 2,500 units, as well as many RV and mobile home parks. In addition to more affordable housing, stakeholders identified a need for more long-term shelters and homeless services to help people stabilize and care for their health. There is also a need for more respite care for people recently being discharged from the hospital without a safe place to stay. Stakeholders identified housing as a foundational need and discussed the importance of Housing First, meaning people need to first be safely and stably housed before they can address their physical and behavioral health needs.

> *"We already had a severe housing shortage before the big fires here. We lost most of our affordable housing. In a pandemic time, that made things much worse ." – Community Stakeholder*

Survey Data

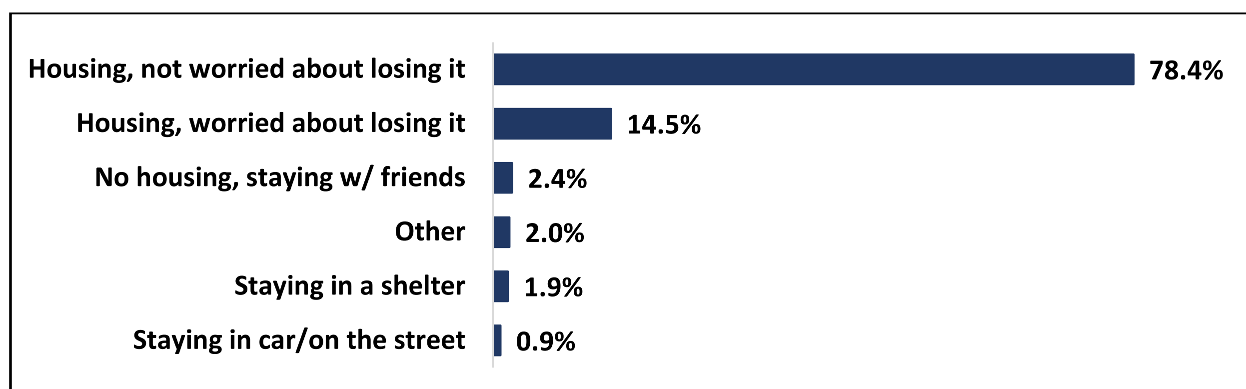
Community members responding to the Community Health Survey reiterated the housing concerns introduced by community stakeholders discussing housing availability, affordability and quality. Some respondents noted the inability to maintain the safety and sanitation of their existing home due to high costs for necessary repairs and maintenance. Respondents voiced concern over the lack of appropriate

[4] DATA SOURCE: County Health Rankings & Roadmaps, 2022 County Health Rankings, 2021.

shelter and services for the homeless, raising concerns about the prevalence of unhoused community members' presence in public parks, streets and informal encampments and the sanitation and safety concerns that arise when basic housing, sanitation and health needs are not being met.

A majority of survey respondents have housing and are not worried about losing it (78.4%), 14.5% have housing and are worried about losing it, and 7.2% reported some form of homelessness.

Figure 1. Percent of Survey Respondents Reporting Housing Status, 2022

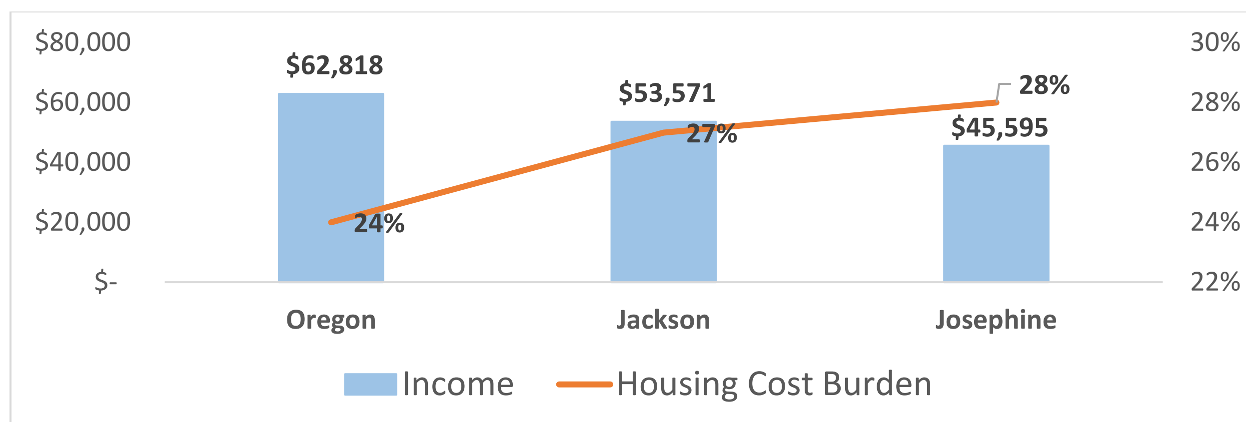


DATA SOURCE: Community Health Needs Assessment Survey, 2022

Secondary Data

The median household income in Jackson ($53,571) and Josephine ($45,595) counties is much lower than Oregon's median income of $62,818. Low-income households have an increased chance of experiencing severe housing cost burden, which is defined as households that spend 50% or more of their income on housing. In Oregon, 24% of residents experience severe housing cost burden. Jackson and Josephine counties are among the counties with the highest number of residents experiencing severe housing cost burden (27% and 28% respectively).

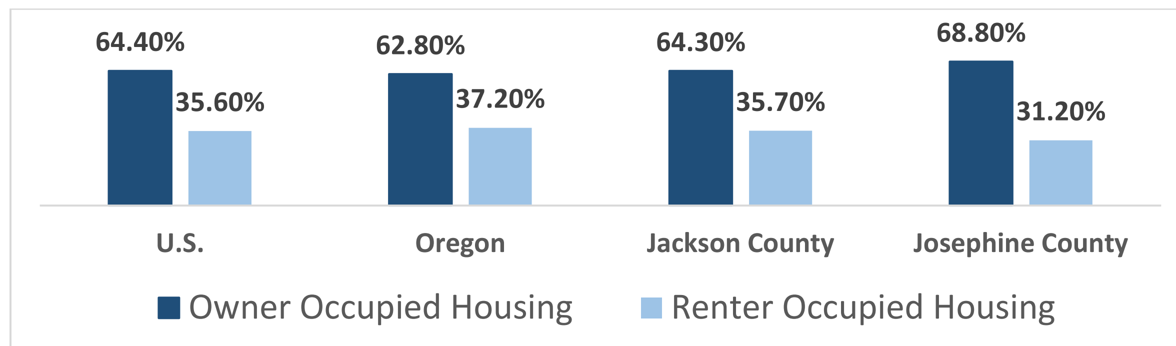
Figure 2. Median Household Income and Percent Households Where Housing Costs are 50% or More of Income by State and County, 2019



DATA SOURCE: Providence Data Hub, 2019 American Community Survey, 5-Year Estimate

Higher proportions of housing units were occupied by owners than by renters (**Figure 3**). Josephine County had the highest proportion of owner-occupied housing units (68.80%) compared to the U.S., Oregon, and Jackson County.

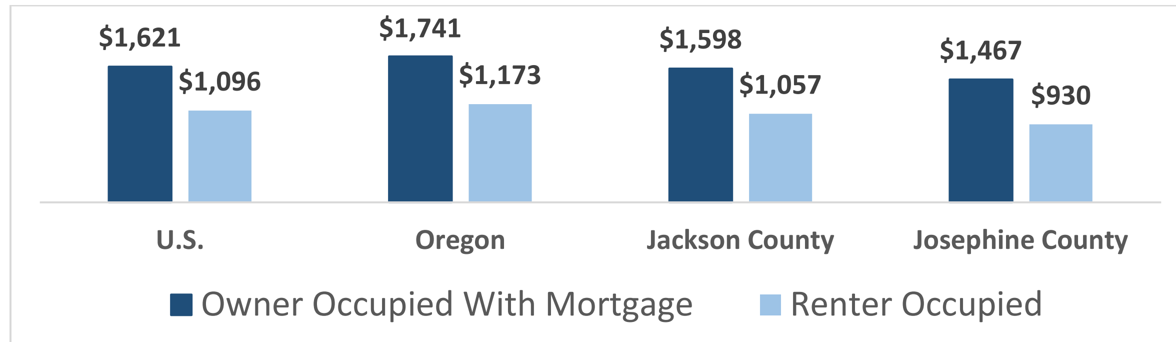
Figure 3. Percent Owner and Renter Occupied Housing Units, by U.S., State, and County, 2016-2020



DATA SOURCE: U.S. Census Bureau, Quick Facts, 5-Year Estimates, 2016-2020

The median monthly housing costs for owners with a mortgage were lower in Jackson County ($1,598) and Josephine County ($1,467) compared to Oregon ($1,741) and the U.S. ($1,621). Similar trends were observed for renter occupied housing units.

Figure 4. Median Monthly Housing Costs by Owner and Renter Occupied Housing Units, by U.S., State, and County, 2016-2020



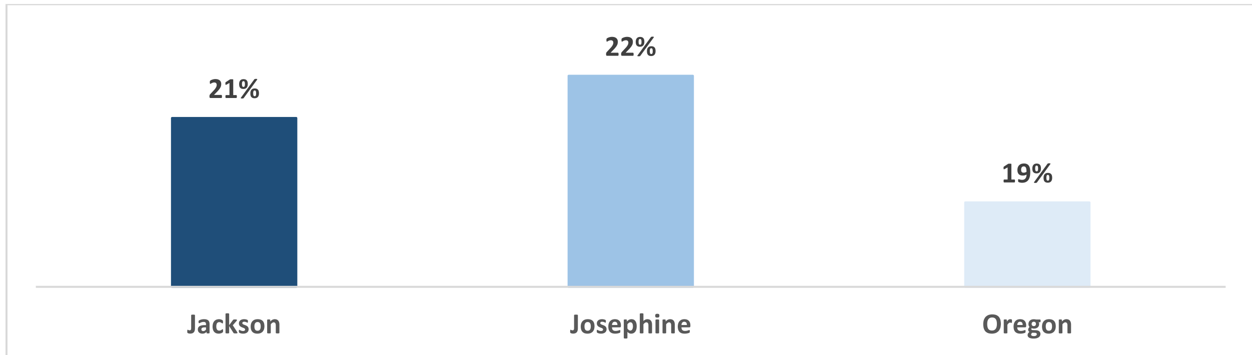
DATA SOURCE: U.S. Census Bureau, Quick Facts, 5-Year Estimates, 2016-2020

County Health Rankings & Roadmaps defines households with 'Severe housing problems' as experiencing at least one of the following four problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities. Severe housing problems can lead to health problems such as infectious and chronic diseases, injuries, and poor childhood development.[5]

[5] DATA SOURCE: County Health Rankings & Roadmaps, 2022 County Health Rankings. Data from 2014-2018 used for this measure.

The following chart (**Figure 5)** shows the percentage of households that qualify as having severe housing problems in the Oregon, Jackson County, and Josephine County.

Figure 5. Percent Households with Severe Housing Problems, by State and County, 2014-2018



DATA SOURCE: County Health Rankings & Roadmaps, 2022 County Health Rankings. Data from 2014-2018 used for this measure.

> *"With the rate of our housing costs, we don't have jobs that match that cost. Even right now with the jobs that are being paid, you could have to make almost twice as much to be able to afford a two-bedroom house reasonably ." – Community Stakeholder*

EXISTING ASSETS AND RESOURCES

Below is a list of community resources addressing homelessness in Jackson and Josephine counties:

- ACCESS
- City of Grants Pass Housing Task Force
- Hearts with a Mission
- Housing Authority of Jackson County
- Jackson County Continuum of Care
- Jackson County Homeless Task Force
- Josephine County Housing and Community Development Council
- Magdalene Home
- Maslow Project
- Rogue Retreat
- Unite Community Action Network (UCAN)

Note: This list of assets was provided by assessment participants and stakeholders. It is not meant to be an exhaustive list of all resources available. Also, note some resources are available in either Jackson or Josephine County only, and some in both counties.

Mental Health

IMPORTANCE AND CONNECTION TO OTHER HEALTH ISSUES

As reported by the Centers for Disease Control and Prevention (CDC), "Evidence has shown that mental disorders, especially depressive disorders, are strongly related to the occurrence, successful treatment, and course of many chronic diseases including diabetes, cancer, cardiovascular disease, asthma, and obesity and many risk behaviors for chronic disease; such as, physical inactivity, smoking, excessive drinking, and insufficient sleep. Mental health is an important component of health-related quality of life (HRQOL), a multi-dimensional concept that focuses on the impact of health status on quality of life."

KEY FINDINGS

Qualitative Data

Stakeholders identified addressing mental health challenges as a very big need in the community and spoke to needing more mental health services across the spectrum of care. The largest gaps in services they identified were crisis response services and more hospital beds for people in mental health crisis. They noted there are few resources for a person experiencing a mental health crisis and often the only options are the emergency room or jail if a crime has been committed. Additionally, stakeholders shared transportation and a lack of safe and stable housing can be barriers to addressing mental health needs, noting the importance of taking a Housing First approach. Stakeholders were particularly concerned about older adults and adults with disabilities who may be experiencing increased social isolation as a result of the pandemic. They also shared they have seen an increase in suicide-related calls and more mental health challenges during the COVID-19 pandemic. Staffing shortages have also contributed to delayed appointments.

> *"Mental health, I think that that's been a widely recognized issue, especially as a dual need with substance abuse. It's a big thing in our area." – Community Stakeholder*

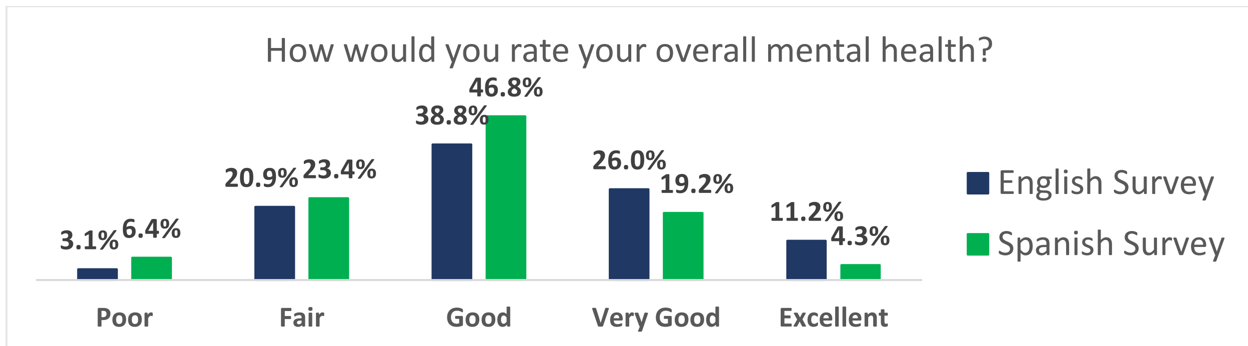
Survey Data

Respondents to the Community Health Survey echoed stakeholder concerns noting the importance of having accessible, affordable and timely mental health care available for all members of the community. They identified a clear need for mental health care for children and teens, including inpatient or residential opportunities, as well as a need for culturally competent bilingual care for our Spanish-speaking community members. Wait times, insurance coverage, number of providers and provider availability were all cited as barriers to receiving prompt mental health care. Respondents referenced anxiety, depression, social isolation and PTSD and noted the recent two years of COVID and impact of wildfires. They expressed concern over the isolation elders and persons living with disabilities may be experiencing and the need to proactively engage these members of the community. While telehealth opportunities were noted, respondents expressed a need for in-person opportunities. Support groups and peer groups were mentioned specifically as well as the need for psychiatrists, psychologists and counselors who offer different approaches and levels of care.

The results of overall mental health status for English and Spanish survey respondents follows a similar distribution. 24% English and 30% Spanish survey respondents rated their overall mental health as 'Poor'

or 'Fair', ~39% English survey respondents and ~47% Spanish survey respondents rated their mental health as 'Good', and just over 37% English survey respondents and 24% Spanish survey respondents rated their mental health as 'Very Good' or 'Excellent'.

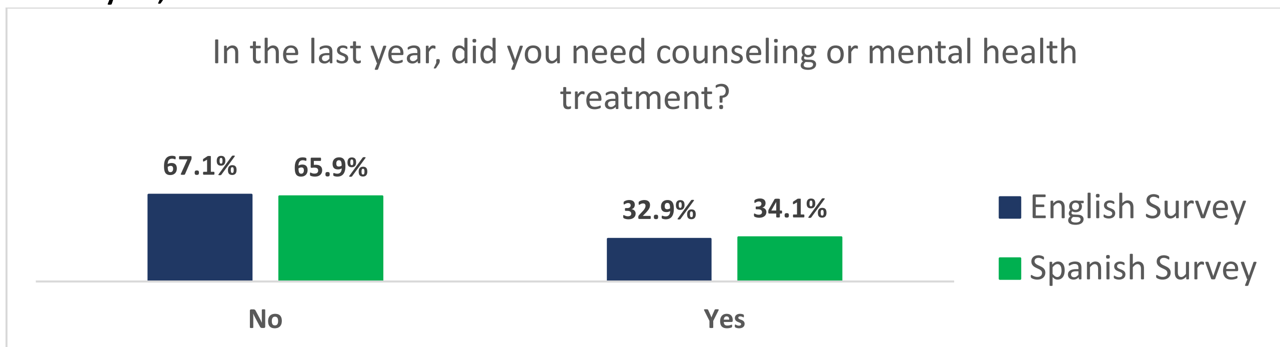
Figure 6. Percent of Survey Respondents Reporting Overall Mental Health Status



DATA SOURCE: Community Health Needs Assessment Survey, 2022

Nearly 33% of English survey respondents and 34.1% of Spanish survey respondents reported needing counseling or mental health services within the last year.

Figure 7. Percent of Survey Respondents Reporting Needing Counseling or Mental Health Services in the last year, 2022



DATA SOURCE: Community Health Needs Assessment Survey, 2022

For respondents who reported not receiving counseling or mental health care, just over 47% and almost 39% did not receive treatment for a mental health condition or support for a personal problem, respectively.

Table 1. Percentage of English Survey Respondents Not Receiving These Types of Needed Counseling or Mental Health Treatment, 2022

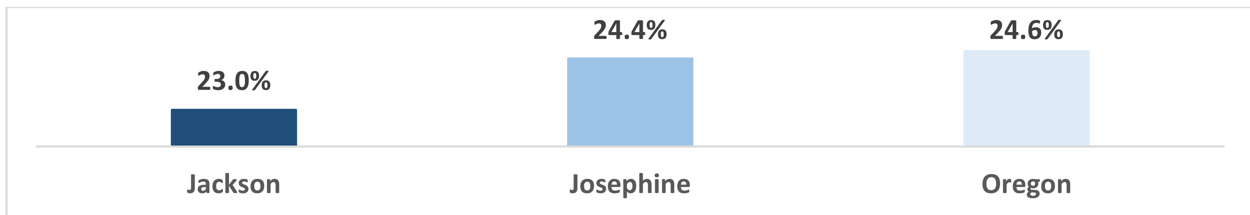
Response	Count	Percentage
Treatment for a mental health condition	110	47.4%
Support for a personal problem	90	38.8%
Other kinds of care	22	9.5%
Counseling to quit tobacco, alcohol, or drug use	10	4.3%
Total Responses	232	100.00%
Reported 'Yes' to getting care	157	-

DATA SOURCE: Community Health Needs Assessment Survey, 2022

Secondary Data

Depression, and more broadly mental health concerns, were frequently mentioned in stakeholder interviews and listening sessions with community members. As shown in Figure X, Jackson and Josephine Counties had a lower prevalence of depression, 23.0% and 24.4% respectively, when compared to Oregon State (24.6%). This measure is defined by the number of respondents aged 18 years and older who reported having been told by a doctor, nurse, or other health professional that they had a depressive disorder.

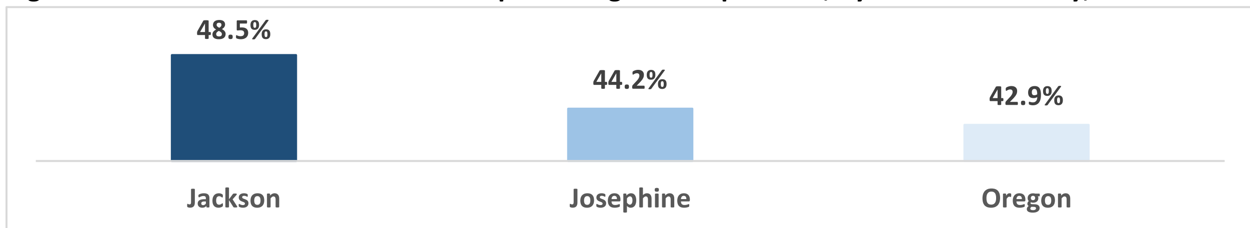
Figure 8. Depression Crude Prevalence (%) Among Adults Aged 18 Years and Older



DATA SOURCE: Behavioral Risk Factor Surveillance System Survey (BRFSS), 2019

Mental health was a significant health concern among youth as reported in the 2020 Student Wellness Survey among 11th grade students in Oregon. Jackson and Josephine counties had higher rates of students reporting signs of depression, 48.5% and 44.2% respectively, than Oregon state (42.9%).

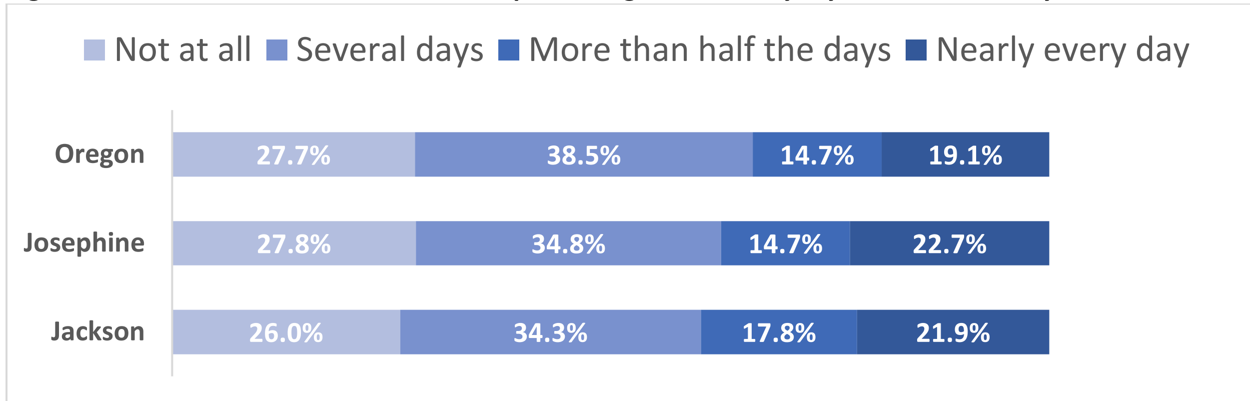
Figure 9. Percent 11th Grade Students Reported Signs of Depression, by State and County, 2020



DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2020

In 2020, 11th grade students reported varying levels of feeling nervous, anxious, or on edge within the previous 30 days from when the Student Wellness Survey was conducted. Most 11th grade students in Jackson and Josephine Counties reported feeling anxious during this 30-day period.

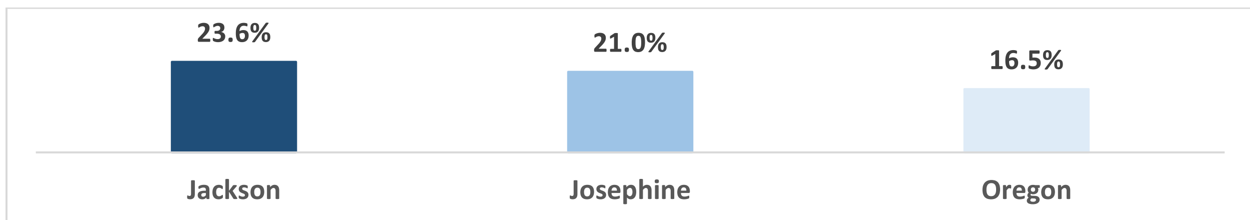
Figure 10. Percent 11th Grade Students Reported Signs of Anxiety, by State and County, 2020



DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2020

In 2020, 11th grade students in Jackson County were more likely to report seriously considering attempting suicide (23.6%), compared to 21.0% in Josephine County and 16.5% in Oregon (Figure X).

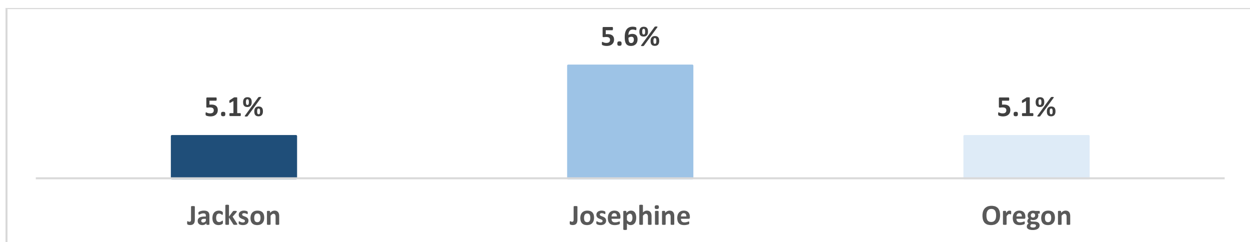
Figure 11. Percent 11th Grade Students Reported Seriously Considering Attempting Suicide, by State and County, 2020



DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2020

In 2020, 11th grade students in Josephine County (5.6%) reported to have attempted suicide, which was more than 11th grade students in Jackson County (5.1%) and Oregon (5.1%).

Figure 12. Percent 11th Grade Students Actually Attempting Suicide, by State and County, 2020



DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2020

EXISTING ASSETS AND RESOURCES

Below is a list of community resources addressing mental health in Jackson and Josephine counties:

- Adapt
- Addictions Recovery Center
- Asante Rogue Regional Medical Center for Behavioral Health Services
- Columbia Care Services
- Compass House
- Crisis Resolution Center
- Family Solutions
- Hope Village
- Integrative Health Center at Rogue Community Health
- Jackson County Health & Human Services Crisis Hotline
- Jackson County Mental Health
- Kairos
- La Clinica
- OnTrack
- Options for Southern Oregon
- Rogue Community Health
- Rogue Retreat
- Southern Oregon Veterans Rehabilitation Center & Clinics

Note: This list of assets was provided by assessment participants and stakeholders. It is not meant to be an exhaustive list of all resources available. Also, note some resources are available in either Jackson or Josephine County only, and some in both counties.

Substance Use

IMPORTANCE AND CONNECTION TO OTHER HEALTH ISSUES

Many adults and youth who develop substance use disorders will also be diagnosed with mental health disorders such as generalized anxiety disorder post-traumatic stress disorder, depression, and bipolar disorder. Research shows 25% of people with serious mental illness also have a co-occurring substance use disorder.[6] In addition to co-occurring mental health, chronic health conditions often co-occur with substance use disorder including chronic pain, cancer, and heart disease, the latter which is independently associated with increased risk from substance use[7].

[6] Common Comorbidities with Substance Use Disorders Research Report. Part 1: The Connection Between Substance Use Disorders and Mental Illness.

[7] Common Comorbidities with Substance Use Disorders Research Report. Part 2: Co-occurring Substance Use Disorder and Physical Comorbidities.

KEY FINDINGS

Qualitative Data

Stakeholders were particularly concerned that many people in the community are not able to receive the care they need to address their substance use/misuse challenges. Stakeholders spoke to needing more detox beds, inpatient substance use disorder (SUD) programs, and Medication-Assisted Treatment facilities. Barriers to accessing treatment services include a lack of affordable childcare, transportation, and stigma. Recruiting certified alcohol and drug counselors from out-of-the-area poses challenges that have contributed to staffing shortages across the region. Older adults may not be able to access SUD treatment because it is not covered by Medicare. People experiencing homelessness may not be able to address their behavioral health needs until safely and stably housed. There is no inpatient SUD treatment or detox for young people and limited outpatient. Stakeholders shared seeing an increase in overdose deaths in 2021, as well as increased substance use/misuse challenges. Staffing shortages during the pandemic have contributed to delayed appointments.

> *"There are still a huge stigma for people suffering with substance use disorders. That people still have a belief that they're bad people and they made bad choices, and that is not the case. No one sets out to become addicted and to live in that life. That is just not true." – Community Stakeholder*

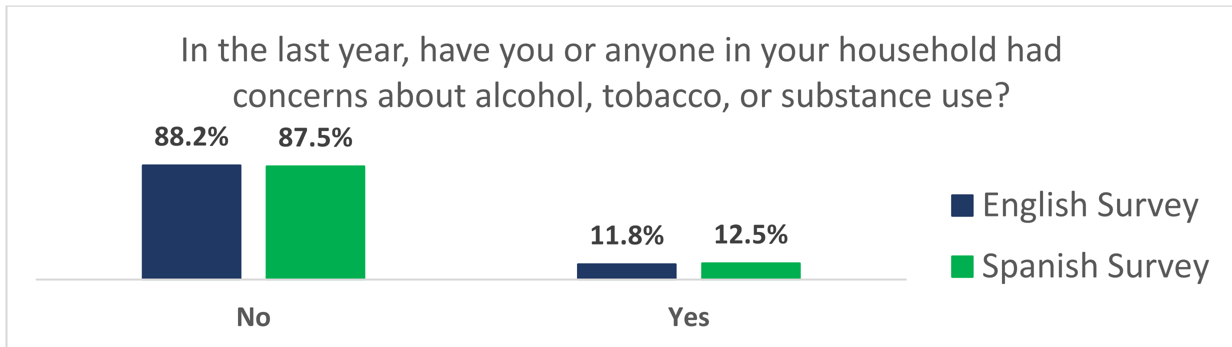
Survey Data

Survey respondents expressed concern over availability and affordability of appropriate treatment programs in the community. They expressed a need for in-patient and residential treatment programs, harm reduction programs such as needle exchange and the public safety concerns related to substance use disorder among the unhoused. When addressing substance use concerns at the community level, the focus was on marijuana and street drugs; tobacco was not mentioned at all. When responding about personal and family health, several respondents commented on their personal efforts to quit smoking.

There were significantly fewer overall responses in the substance use category when speaking of one's own personal and familial health. Multiple comments focused on strengthening the safety of the community by providing appropriate substance use treatment for impacted community members, enhancing the power and presence of law enforcement to reduce related crime and the need for 'cleaning up' our streets, parks and green spaces. Community members expressed concern over unsafe needle disposal in outdoor spaces, particularly parks and playgrounds, and the safety and security of children and families when encountering individuals involved with substance use in those spaces. Many comments acknowledged the intersection of substance use with other factors such as mental health, poverty and houselessness and acknowledged a need for more wrap-around services for these community members.

The distribution of individuals or household members having concerns about alcohol, tobacco, or substance use in the last year were similar between the English and Spanish survey respondents.

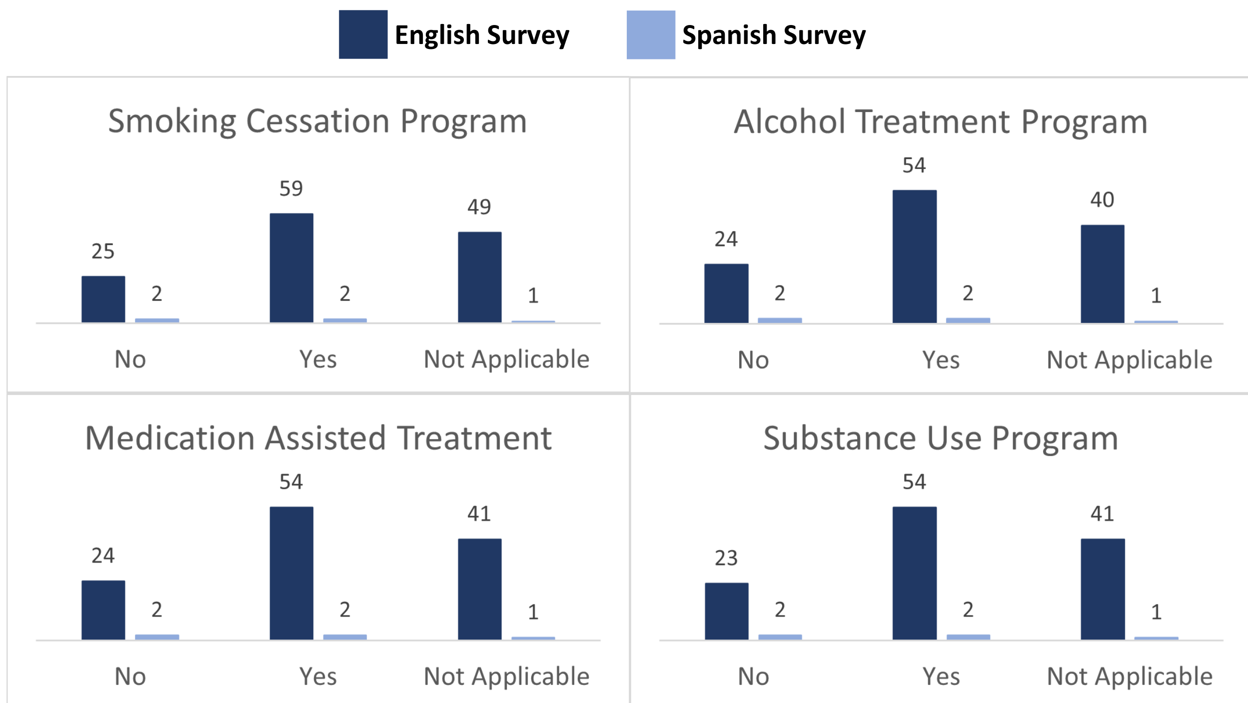
Figure 13. Percent of Survey Respondents Reporting Concerns About Alcohol, Tobacco, or Substance Use in the Last Year, 2022



DATA SOURCE: Community Health Needs Assessment Survey, 2022

The survey respondents reporting 'yes' to having concerns about alcohol, tobacco, or substance use stated whether they were able to get help with each concern (**Figure 14**).

Figure 14. Count of Survey Respondents Reporting the Ability to Get Help with Alcohol, Tobacco, or Substance Use, 2022

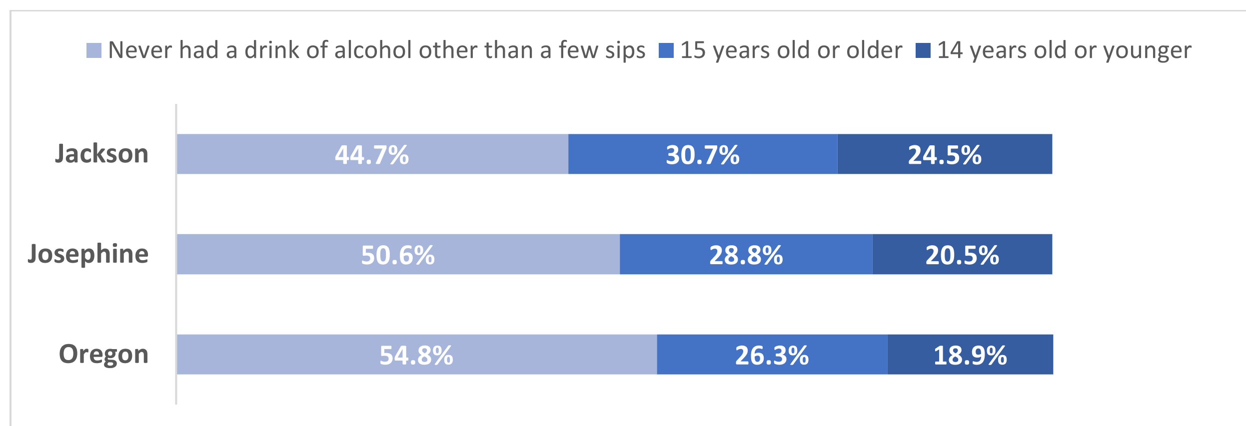


DATA SOURCE: Community Health Needs Assessment Survey, 2022

Secondary Data

As reported in the 2020 Student Wellness Survey, "youth who initiate alcohol use at an early age (14 years or younger) are four times more likely to experience lifetime dependency and are more likely to be involved in alcohol-related motor vehicle crashes, personal injury, and physical fights." A greater percentage of 11th graders in Jackson (24.5%) and Josephine (20.5%) Counties first drank alcohol at 14 years old or younger compared to Oregon state (18.9%).

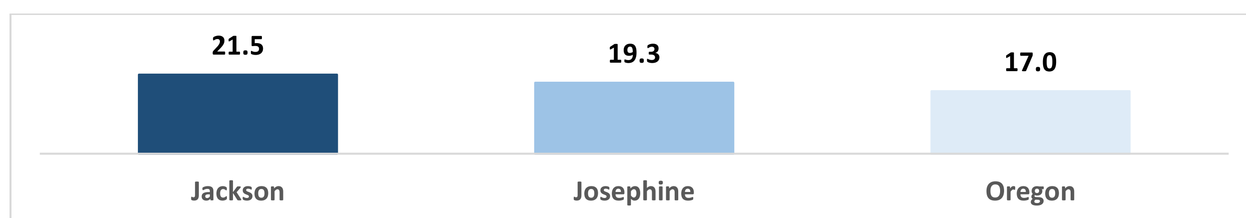
Figure 15. Percent 11th Graders Reported Age When First Consuming Alcohol, by State and County, 2020



DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2020

In addition to the age when alcohol was first consumed, 11th graders in Jackson (21.5 days) and Josephine (19.3 days) Counties reported a greater number of days having at least one drink of alcohol in the last 30 days compared to Oregon (17.0 days).

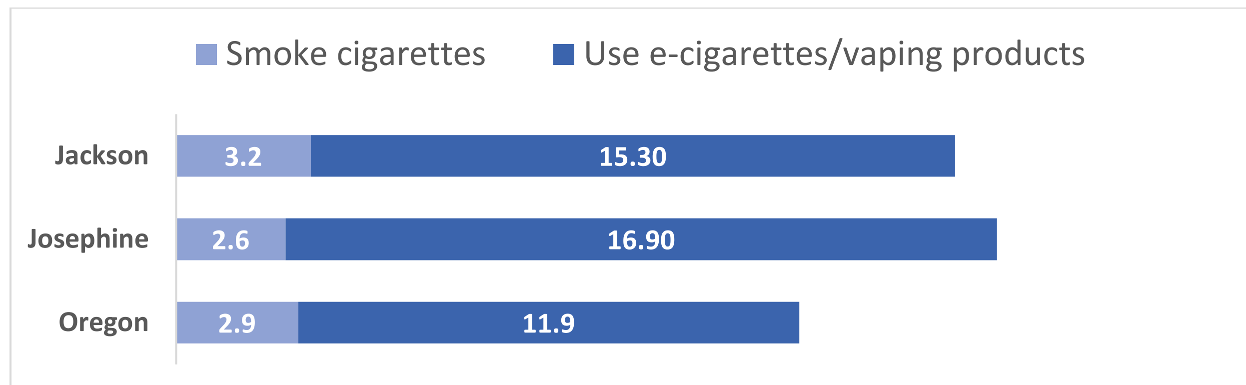
Figure 16. Number of Days 11th Graders Reported Having At Least One Drink of Alcohol in the Last 30 Days, by State and County, 2020



DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2020

Eleventh graders in Jackson and Josephine Counties reported smoking cigarettes and using e-cigarettes or vaping products a greater number of days in the last 30 days compared to Oregon. Students preferred using e-cigarettes or vaping products over smoking cigarettes.

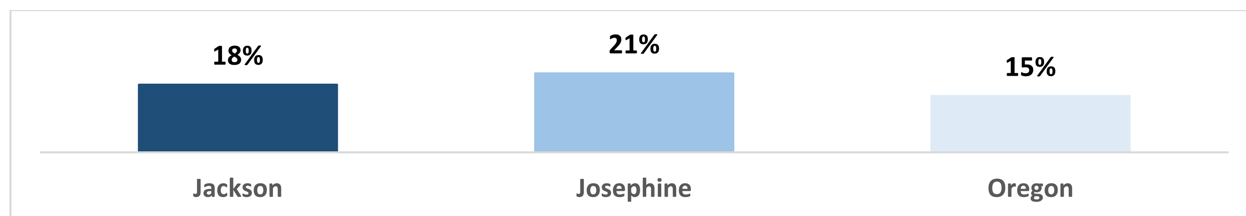
Figure 17. Number of Days 11th Graders Reported Smoking Cigarettes and Using E-Cigarettes in the Last 30 Days, by State and County, 2020



DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2020

As shown in **Figure 18**, adults in Josephine County (21%) were more likely report smoking cigarettes than in Jackson County (18%) and Oregon (15%).

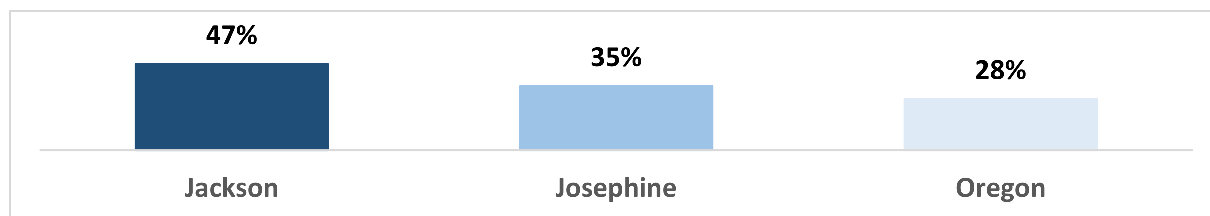
Figure 18. Age-Adjusted Percent Adults Reported Current Cigarette Smoking, By State and County, 2019



DATA SOURCE: Behavioral Risk Factor Surveillance System Survey (BRFSS), County Health Rankings, 2019

As shown in **Figure 19**, the percent of motor vehicle crash deaths involving alcohol was higher in Jackson (47%) and Josephine (35%) Counties than in Oregon (28%). This indicator directly measures the relationship between motor vehicle crash deaths and alcohol.

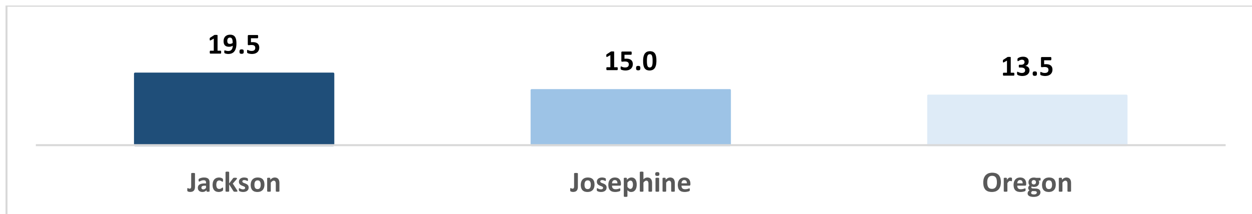
Figure 19. Percentage of Motor Vehicle Crash Deaths with Alcohol Involvement, by State and County, 2016-2020



DATA SOURCE: Fatality Analysis Reporting System, County Health Rankings, 2016-2020

Eleventh graders in Jackson (19.5 days) and Josephine (15.0 days) Counties reported a greater number of days having used marijuana in the last 30 days compared to Oregon (13.5 days).

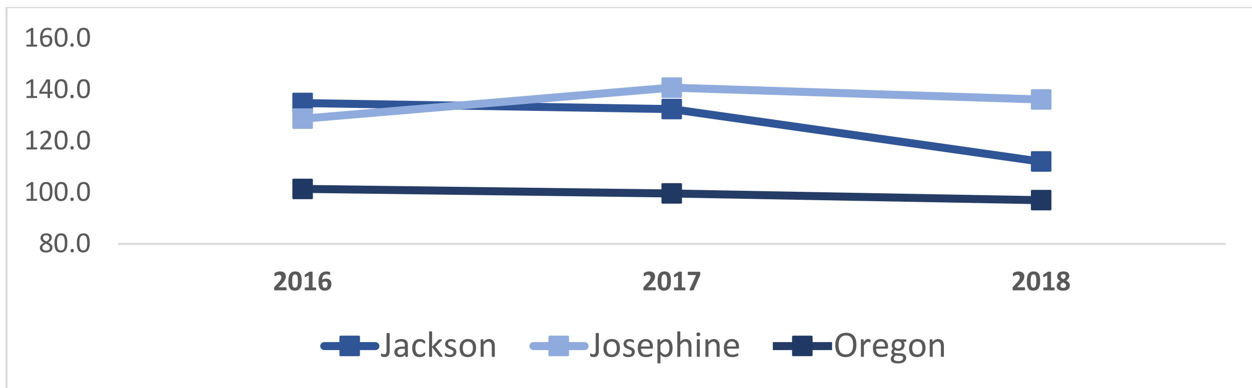
Figure 20. Number of Days 11th Graders Reported Using Marijuana in the Last 30 Days, by State and County, 2020



DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2020

From 2016 to 2018, the overdose hospitalization rate for all drugs trended down in Oregon and Jackson County while Josephine County saw an increase over that same period.

Figure 21. All Drugs Overdose Hospitalization Rate per 100,000 Population, By State and County, 2016-2018



DATA SOURCE: Oregon Health Authority, Center for Health Statistics, Public Health Division, Oregon Hospital Discharge Data as cited by Prescribing and Drug Overdose Data Dashboard, 2016-2018

EXISTING ASSETS AND RESOURCES

Below is a list of community resources addressing substance use disorder in Jackson and Josephine counties:

- Adapt
- Addictions Recovery Center
- Asante Rogue Regional Medical Center for Behavioral Health Services
- Columbia Care Services
- Compass House
- Crisis Resolution Center
- Family Solutions
- Hope Village
- Integrative Health Center at Rogue Community Health
- Jackson County Health & Human Services Crisis Hotline

- Jackson County Public Health Syringe Exchange
- Kairos
- La Clinica
- OnTrack
- Options for Southern Oregon
- Rogue Community Health
- Rogue Retreat
- Southern Oregon Veterans Rehabilitation Center & Clinics

Note: This list of assets was provided by assessment participants and stakeholders. It is not meant to be an exhaustive list of all resources available. Also, note some resources are available in either Jackson or Josephine County only, and some in both counties.

Access to Health Care Services

IMPORTANCE AND CONNECTION TO OTHER HEALTH ISSUES

Primary care resources include community clinics, pediatricians, family practice physicians, internists, nurse practitioners, pharmacists, telephone advice nurses, urgent care clinics, emergency departments, and other similar resources. Primary care services are typically the first point of contact when an individual seeks health care. These services are the front line in the prevention and treatment of common diseases and injuries in a community.

KEY FINDINGS

Qualitative Data

"Language access [is] a really big need within the community. We have a large Hispanic, Latinx community. Getting resources available to them in Spanish, especially in a timely manner, I think a lot of organizations try, but they don't have the resources to have translation and other things available in the same way that they do for English. That creates a lot of need and disparity among that population." – Community stakeholder

Stakeholders identified a need for more specialists, bilingual and bicultural providers, and care coordination. They emphasized transportation is the primary barrier to care and can be challenging for people living in rural areas traveling to urban areas for care, but also for people needing to travel to other parts of the state for specialty care. Cost of care is another barrier, even with insurance and charity care. The following populations may experience additional barriers to accessing responsive, high-quality, and timely care: people experiencing homelessness, people identifying as LGBTQIA+, people with behavioral health challenges, older adults, the Latino/a community, and veterans. As a result of the COVID-19 pandemic many people may have delayed care, either by choice or because of a lack of health care capacity. Stakeholders were concerned about staffing issues in health care, leading to longer wait times. Additionally, telehealth has

improved access for some, but created additional technology barriers for others. The COVID-19 pandemic highlighted the health disparities in the community and the need to continue to build trust with the community.

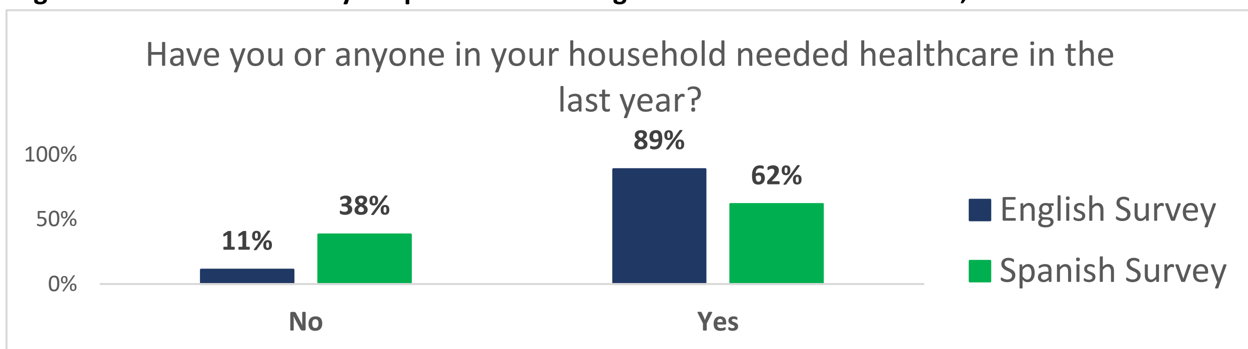
Survey Data

Community Health Survey respondents expressed significant concern over access to care when answering open-ended questions. Availability of primary care providers and specialists, extensive wait times, limited days and hours of service, care delays related to COVID, insurance restrictions, clinic closures and quality of care were all cited as barriers to receiving appropriate, timely health care. Both English and Spanish speaking respondents cited a need for bilingual, culturally competent care for Spanish-speaking community members. There is also a need for non-discriminatory, inclusive care for LGBTQIA+ community members, people with disabilities, and those experiencing mental health and or substance use disorders. Survey respondents expressed an extensive need for specialists (see Appendix 1 for detailed list). Several community members specifically mentioned the need for familiarity with Ehlers-Danlos Syndrome. Occupational, speech and physical therapy were all mentioned as areas of need.

Community members expressed concern over having to travel for care, both between counties in our region, and to more distant locations for higher levels of care. Those in more remote areas expressed a need for clinics closer to home, citing the rising costs of fuel and the inconvenience or impossibility of traveling to larger cities for care, particularly during 'normal' clinic hours. Respondents cited the need for urgent care options, evening and weekend options and easier access to primary care providers for ongoing concerns. The cost of care was commonly referenced, including the purchase and maintenance of insurance, copays, deductibles and out of pocket costs, with some respondents stating that the cost of care is so prohibitive they do not seek care when needed. Respondents noted the lack of affordable dental and vision care, costs of assistive devices necessary for daily living and the cost of prescription medications as areas of concern for our community.

Most survey respondents required health care in the past year (89%). Of those, the majority were able to access a provider and receive care; however, many respondents report they delayed care or received no care. For Spanish-speaking respondents, of the 62% who sought health care, the majority reported receiving all or some health care (81%) and very few reported delayed or no care.

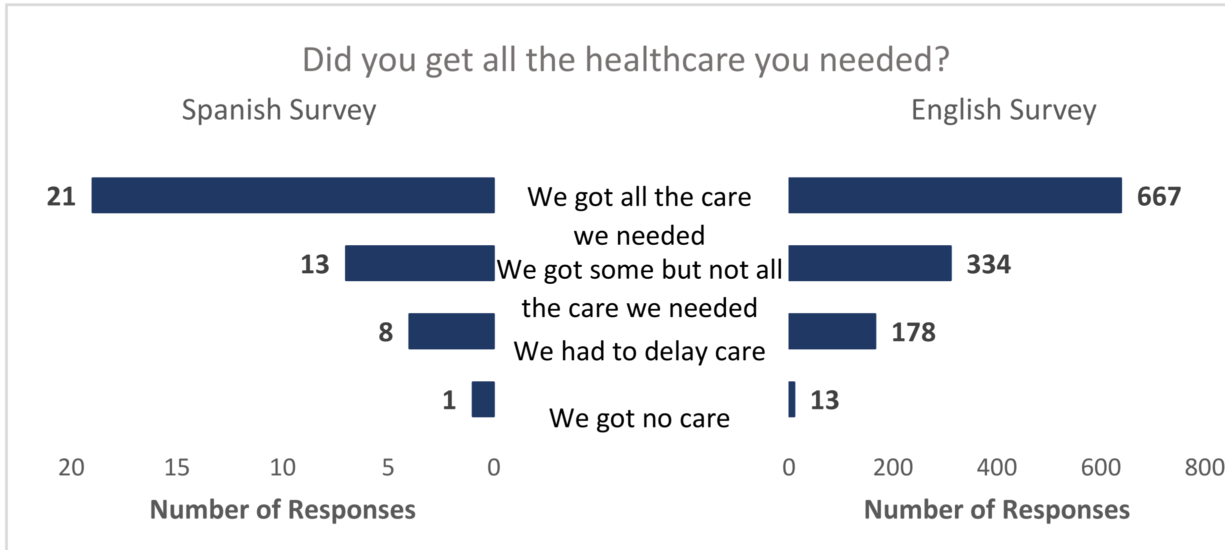
Figure 22. Percent of Survey Respondents Needing Healthcare in the Last Year, 2022



DATA SOURCE: Community Health Needs Assessment Survey, 2022

Of the survey respondents who reported 'yes' to needing healthcare in the last year, **Figure 23** shows whether those respondents got all the healthcare they needed.

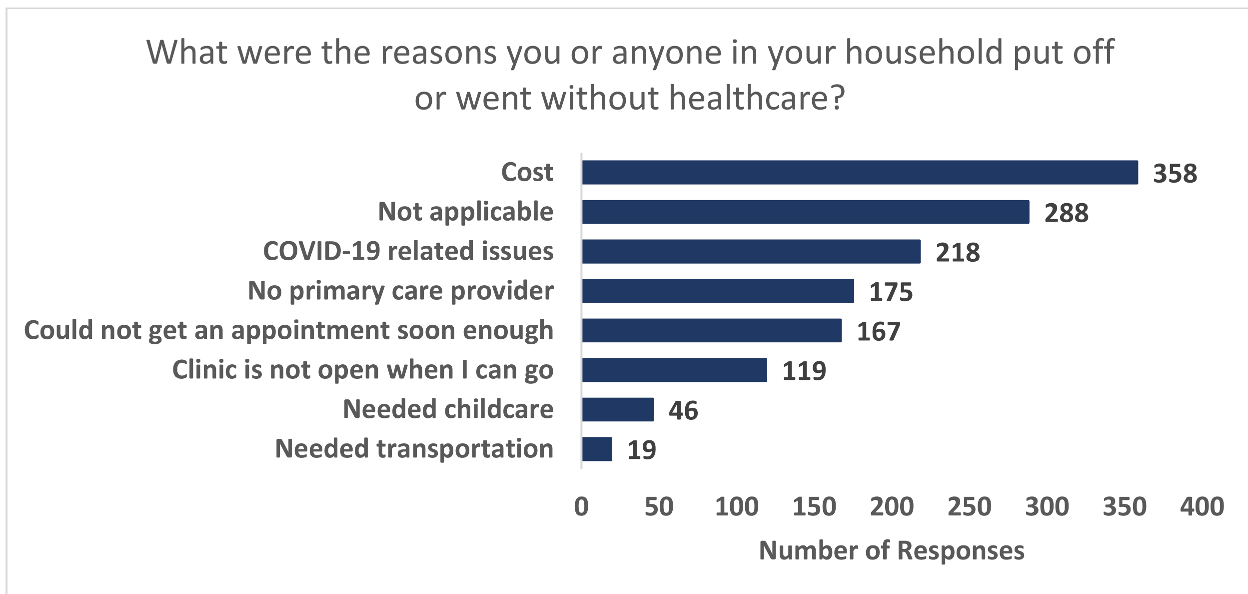
Figure 23. Number of Survey Respondents Obtaining Needed Healthcare in the Last Year, 2022



DATA SOURCE: Community Health Needs Assessment Survey, 2022

The main reasons for delaying care or going without care was associated with cost (30%) and the inability to get an appointment (27%). Nearly 19% had their appointments canceled or delayed due to COVID-19. Spanish-speaking respondents cited cost (27%) as the primary reason for not receiving health care, followed by COVID-related issues (14%) and not having a primary care provider (11%) as the second most common reasons.

Figure 24. Reasons Survey Respondents Put Off or Went Without Healthcare, 2022

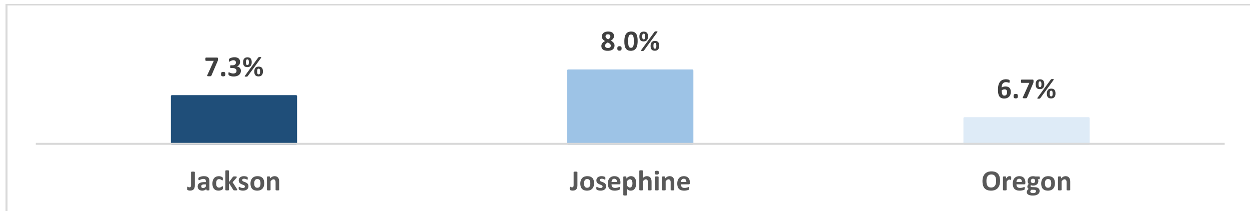


DATA SOURCE: Community Health Needs Assessment Survey, 2022

Secondary Data

In Jackson County 15,818 persons are reported to be uninsured while 6,854 are uninsured in Josephine County. Across the state a total of 275,522 Oregonians is reported to be uninsured. Uninsured adults are less likely to receive preventive services for chronic conditions such as diabetes, cancer, and cardiovascular disease. Similarly, children without health insurance coverage are less likely to receive appropriate treatment for conditions like asthma or critical preventive services such as dental care, immunizations, and well-child visits that track developmental milestones.

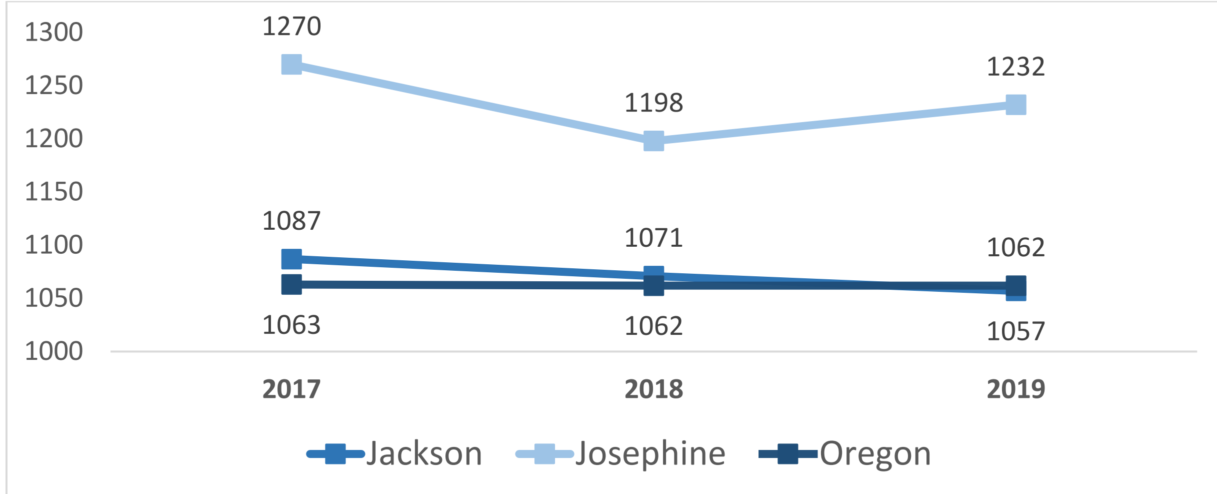
Figure 25. Percent of Population Uninsured, by County and State, 2019



DATA SOURCE: Providence Data Hub, 2019 American Community Survey, 5-Year Estimate

In 2019, there was one primary care provider to serve every 1,057 people in Jackson County. That ratio is similar for Oregon (1:1060) as well. However, in Josephine County, there is one primary care provider for every 1,232 people, making access to care more difficult for residents of Josephine County.

Figure 26. Ratio Of Population to One Primary Care Provider, by State and County, 2017-2019



DATA SOURCE: Area Health Resources Files (AHRF) 2020-2021. US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Workforce, Rockville, MD. County Health Rankings, 2017-2019.

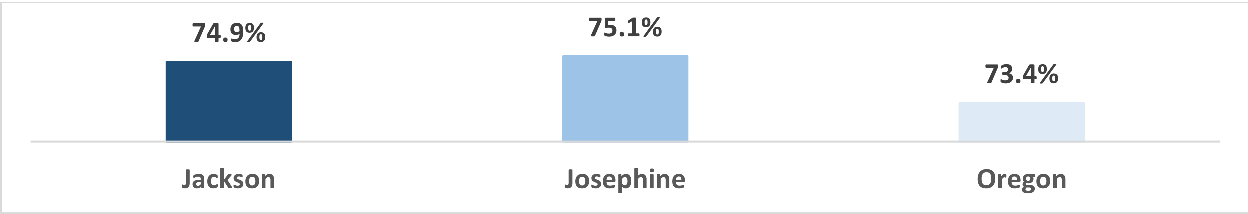
Ratio of population to one mental health provider

In 2021, County Health Rankings & Roadmaps cites the ratio of the population to mental health providers at 170:1 for the state of Oregon, with Jackson County coming in at 180:1 and Josephine County at 110:1. The mental health ratios may be reflective of the proliferation of telehealth options

that have expanded avenues of access; however it is worth noting that telehealth options may not be universally accessible due to insurance limitations, costs and technological inequities.[8]

In 2011, approximately two-thirds of US adults reported having been to a doctor for a routine general physical examination. Visits to primary care providers for routine preventive exams has been increasing. Both Jackson and Josephine counties report slightly higher results than the rest of the state. Accessing preventive healthcare services, such as getting routine physical checkups, receiving recommended vaccinations on appropriate schedules, and checking blood pressure and cholesterol and maintaining them at healthy levels, can reduce morbidity and mortality from chronic diseases.

Figure 28. Annual Checkup Crude Prevalence



DATA SOURCE: Providence Data Hub, Behavioral Risk Factor Surveillance System (BRFSS), 2019

EXISTING ASSETS AND RESOURCES

Below is a list of community resources addressing access to care through the provision of health care services in Jackson and Josephine Counties:

- AllCare (CCO)
- CareOregon
- Jackson Care Connect (CCO)
- Jackson County Health & Human Services
- Josephine County Health & Human Services
- La Clinica
- Rogue Community Health
- Siskiyou Community Health Center
- Below is a list of community resources addressing access to care through the provision of transportation in Jackson and Josephine counties:
- Rogue Valley Medical Transport
- Valley Lift (Rogue Valley Transportation District)

Note: This list of assets was provided by assessment participants and stakeholders. It is not meant to be an exhaustive list of all resources available. Also, note some resources are available in either Jackson or Josephine County only, and some in both counties.

[8] County Health Rankings & Roadmaps, 2022 County Health Rankings. Data from 2021 used for this measure.

Affordable Childcare and Preschools

IMPORTANCE AND CONNECTION TO OTHER HEALTH ISSUES

Many children in the US attend early care and education (ECE) programs before entering kindergarten. Examples of ECE programs include public or private preschool, childcare centers, or Head Start. ECE programs play a vital role in outcomes for children. ECE programs with health components (for example, nutrition, screenings, and links to health insurance), such as Head Start, show real time and long-term health benefits for participants, including higher immunization, screening, and identification rates; improved mental health; and reduced smoking.[9]

KEY FINDINGS

Qualitative Data

Stakeholders prioritized affordable childcare and preschools because it is foundational for family stability and well-being. Reliable and affordable childcare allows caregivers to return to work and attend needed health care services. They described childcare as almost nonexistent in the community, hurting workers in all industries. Stakeholders shared there is a lack of childcare centers in the community and they have long waitlists. The cost of childcare is prohibitive for many families in relation to their income. Transportation can also be a barrier. Childcare is necessary for parents needing to go to a medical detox or residential treatment program.

> *"Our daycare exceeds our mortgage. The current model for this can't survive." – Community Member*

Survey Data

Community members responding to the community health survey corroborated stakeholder concerns around childcare citing barriers to both employment and seeking necessary medical care for either themselves or their children because childcare was not available. Transportation, cost and availability are all factors. Respondents cited COVID as a factor in changing the availability of childcare in our area stating that some centers had closed and others had lengthy wait lists in the wake of mandates and temporary closures.

Secondary Data

A county is considered a childcare desert if there are more than three children for every regulated childcare slot. Regulated care includes childcare centers and home-based providers that are licensed by the state. Jackson County is classified as a 'severe childcare desert' with only 9% of children ages 0–2-years and 30% of children ages 3–5-years with potential access to a regulated childcare slot. Josephine County is only slightly better with the 'childcare desert' classification (14% and 27% respectively).

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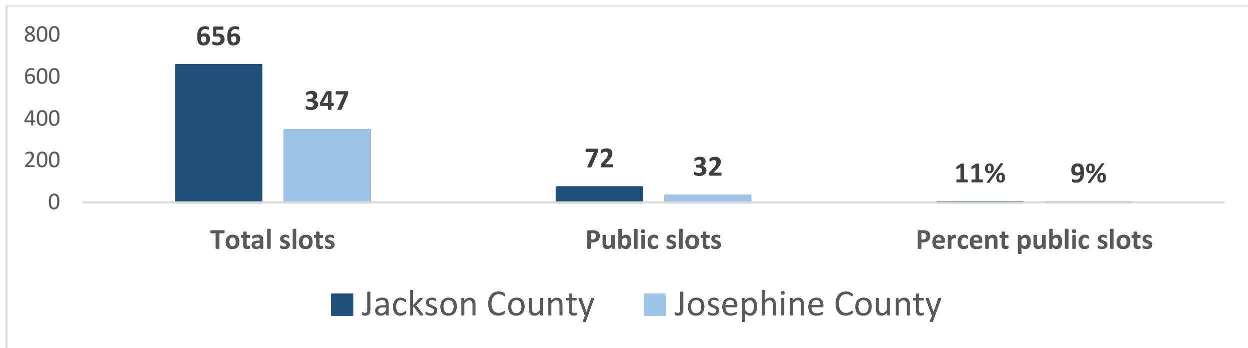
[9] Health Affairs, Culture of Health, Health Policy Brief, The Effects of Early Care and Education on Children's Health, April 2019

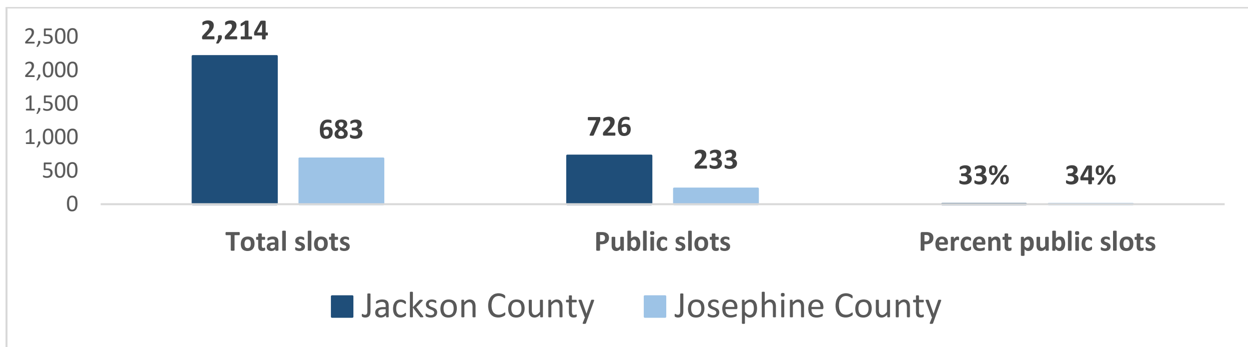
In addition to the lack of regulated childcare slots in Jackson and Josephine Counties, there is a limited number of publicly funded childcare slots. Examples include Head Start, Preschool Promise, Baby Promise, Federal Land Tribal Head Start, and Federal Migrant and Seasonal Head Start. Publicly funded childcare allows families to pay less out of pocket. With limited publicly funded slots, few low-income families have access to affordable childcare.

Figure 29. Percent of Publicly Funded Regulated Childcare Slots Ages 0-2, by County, 2020



DATA SOURCE: Oregon State University, Collect of Public Health and Human Sciences, Oregon Child Care Research Partnership, Oregon's Child Care Deserts 2020: Mapping Supply by Age Group and Percentage of Publicly Funded Slots, April 2021

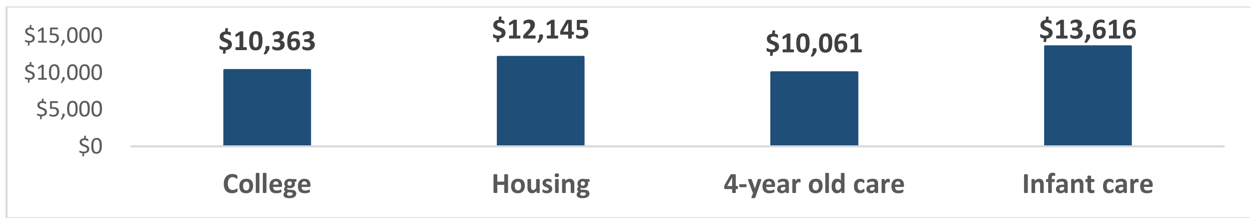
Figure 30. Percent of Publicly Funded Childcare Slots Ages 3-5, by County, 2020



DATA SOURCE: Oregon State University, Collect of Public Health and Human Sciences, Oregon Child Care Research Partnership, Oregon's Child Care Deserts 2020: Mapping Supply by Age Group and Percentage of Publicly Funded Slots, April 2021

In Oregon, the average annual cost of childcare for an infant is $13,616. This is higher than the average annual costs for both in-state tuition at a four-year public college ($10,363) and the average household rent ($12,145).

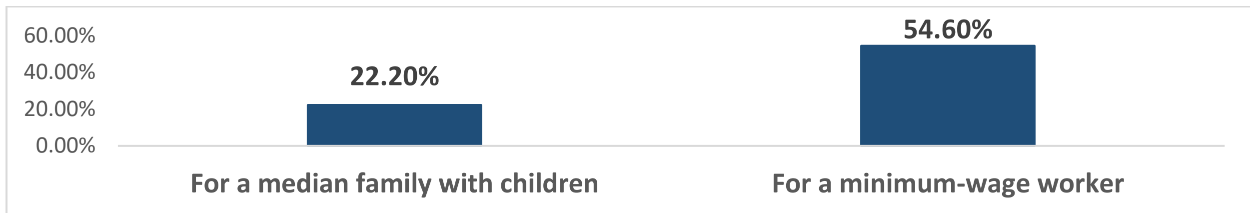
Figure 31. Average Annual Costs of Child Care Compared to Housing and College in Oregon, 2020



DATA SOURCE: Economic Policy Institute, Child Care Costs in the United States, 2020

The Department of Health and Human Services Affordability Standard states childcare should cost no more than 7% of a family's income. In Oregon, a median family with children pays 22% of their income for childcare while a minimum-wage worker pays 54.6% of their income.

Figure 32. Infant Care Costs as a Share of Income in Oregon, 2020



DATA SOURCE: Economic Policy Institute, Child Care Costs in the United States, 2020

EXISTING ASSETS AND RESOURCES

Below is a list of community resources addressing affordable childcare and education in Jackson and Josephine counties:

- YMCAs
- Kids Unlimited
- Boys and Girls Club
- Oregon Child Development Coalition
- Southern Oregon Head Start
- Southern Oregon Education Services District – Childcare Resource Network
- Family Nurturing Center
- Southern Oregon Child and Family Council

Note: This list of assets was provided by assessment participants and stakeholders. It is not meant to be an exhaustive list of all resources available. Also, note some resources are available in either Jackson or Josephine County only, and some in both counties.

Economic Insecurity

IMPORTANCE AND CONNECTION TO OTHER HEALTH ISSUES

Access to affordable and clean housing, stable employment, quality education, and adequate food are vital for good health. Research shows that the social determinants of health — such as quality housing, adequate employment and income, food security, education, and social support systems — influence individual health as much as health behaviors and access to clinical care. Without access to meeting these basic needs, individuals cannot experience full and healthy lives.

KEY FINDINGS

Qualitative Data

Stakeholders were primarily concerned about a lack of living wage jobs, meaning jobs that pay people enough to meet their needs. Stakeholders shared the cost of housing is disproportionately high compared to people's income. Additionally, the cost of health care can be a burden, with a significant medical event leading people to be unable to pay for their housing. For families that were already behind on payments prior to the pandemic, it only worsened the situation. The COVID-19 pandemic and the wildfires of 2020 have jeopardized people's housing and ability to pay for services. For families needing to isolate or quarantine, they may have lost wages, further putting stress on their financial situation.

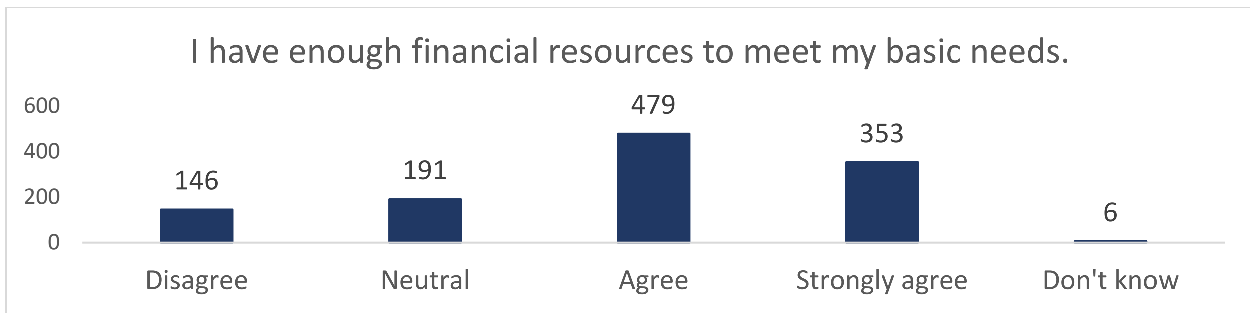
> *"No doubt economic insecurity, lack of a living wage, is a big problem. There's plenty of jobs out there, but are they paying enough for a person to actually take care of their housing needs? Usually not." – Community Stakeholder*

Survey Data

Affordability was a key concern among community members responding to the Community Health Survey. When discussing the community at large, there were mentions of the cost of health care, insurance, medications and related services. There were many references to the need for low or no-cost services for vulnerable community members, people of color, children, families and elders. When asked to focus on personal needs for self and family, financial concerns topped the list with respondents citing these same areas of concern but also referencing food, fuel and housing costs as well as wages, inflation and their concerns over their ability to sustainably provide for their families. Several respondents called attention to "middle-class" community members who are outside the parameters for most assistance and are struggling in the current economic climate.

The majority of respondents agree or strongly agree (71%) they have the financial resources to meet their basic needs.

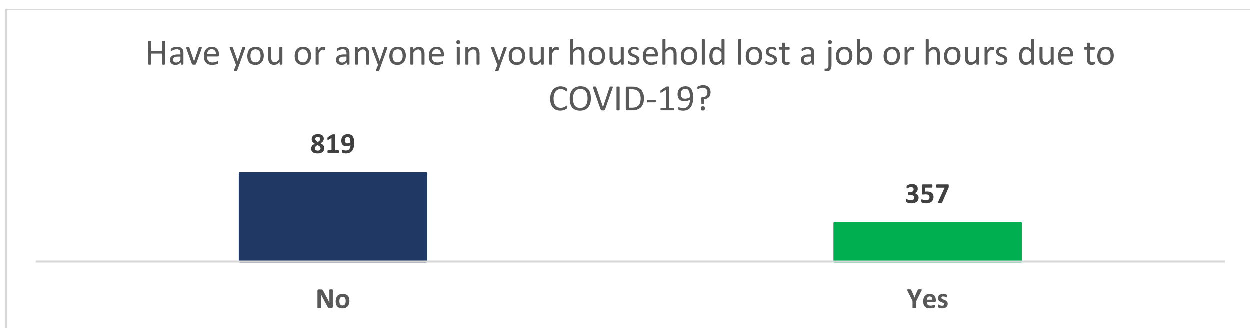
Figure 33. Number of Respondents Reporting Ability to Afford Basic Needs



DATA SOURCE: Community Health Needs Assessment Survey, 2022

Although most respondents reported they can meet their financial needs, many hold two jobs to afford their living expenses (73%), and nearly one-third reported they or someone in their household lost a job or hours due to COVID-19. For Spanish-speaking respondents, 41% reported they needed a second job to afford living expenses and about 56% reported losing a job or hours due to COVID-19.

Figure 34. Number of Respondents Reporting Losing a Job or Hours due to COVID-19

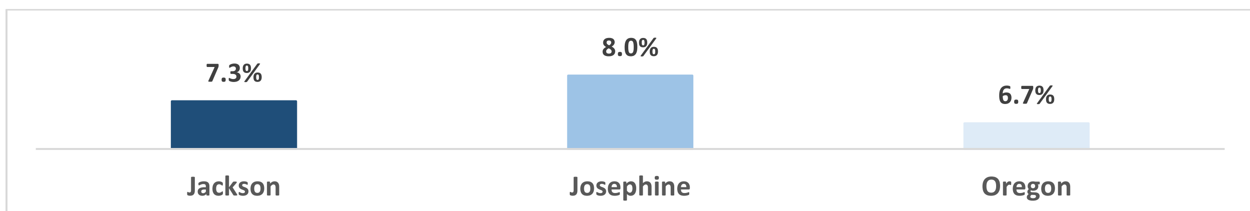


DATA SOURCE: Community Health Needs Assessment Survey, 2022

Secondary Data

In Jackson County 77,756 people are reported to be living below 200% of the Federal Poverty Level while 37,050 are living below the poverty level in Josephine County. Statewide, 1,248,819 Oregonians are reported to be living below 200% of the Federal Poverty Level. For reference, in 2019, 200% Federal Poverty Level was equivalent to an annual household income of $51,500 or less for a family.

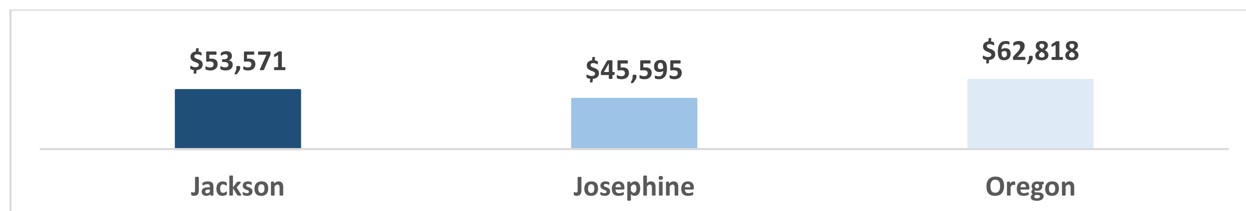
Figure 35. Percentage of the Population below the 200% Federal Poverty Level, by County and State, 2019



DATA SOURCE: Providence Data Hub, 2019 American Community Survey, 5-Year Estimate

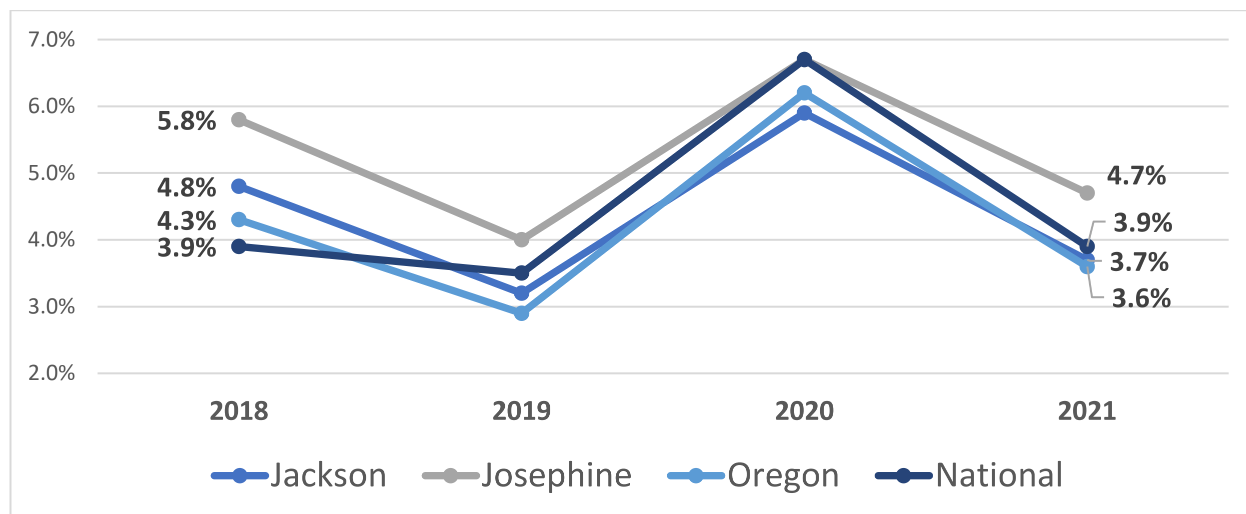
Household median incomes includes the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not. Because many households consist of only one person, average household income is usually less than average family income. Jackson and Josephine counties show significantly lower median income than reported elsewhere in Oregon.

Figure 36. Household Median Income, by State and County, 2019



DATA SOURCE: Providence Data Hub, 2019 American Community Survey, 5-Year Estimate

Figure 37. Trend in Unemployment Rate, by U.S., State, and County, March 2019 – March 2022



DATA SOURCE: for U.S. data, U.S. Bureau of Labor Statistics, Current Population Survey, 2018-2021 and for state and county data, U.S. Bureau of Labor Statistics, Local Area Unemployment Statistics, 2018-2021

EXISTING ASSETS AND RESOURCES

Below is a list of community resources addressing economic insecurity in Jackson and Josephine counties:

- ACCESS
- Confident Staffing
- Express Employment Professionals
- Goodwill Employment and Training Center
- Josephine County Food Bank
- Maslow Project
- Oregon Employment Department

- Rogue Retreat
- St. Vincent de Paul
- The Job Council
- United Way
- WorkSource Rogue Valley

Note: This list of assets was provided by assessment participants and stakeholders. It is not meant to be an exhaustive list of all resources available. Also, note some resources are available in either Jackson or Josephine County only, and some in both counties.

Chronic Conditions

IMPORTANCE AND CONNECTION TO OTHER HEALTH ISSUES

Extended care services, which include specialty care, are focused on the treatment of a particular disease. Primary and specialty care go hand in hand, and without access to specialists, people are often left to manage chronic diseases such as diabetes, hypertension, obesity, and heart disease on their own. When people lack access to primary care, specialists or adequate information on how to prevent, manage, and control their health conditions, those conditions tend to worsen. Additionally, people focused on essentials of living, such as economic instability, housing, childcare, food insecurity or other basic needs may not have the time, money and energy to dedicate to managing health conditions.

KEY FINDINGS

Qualitative Data

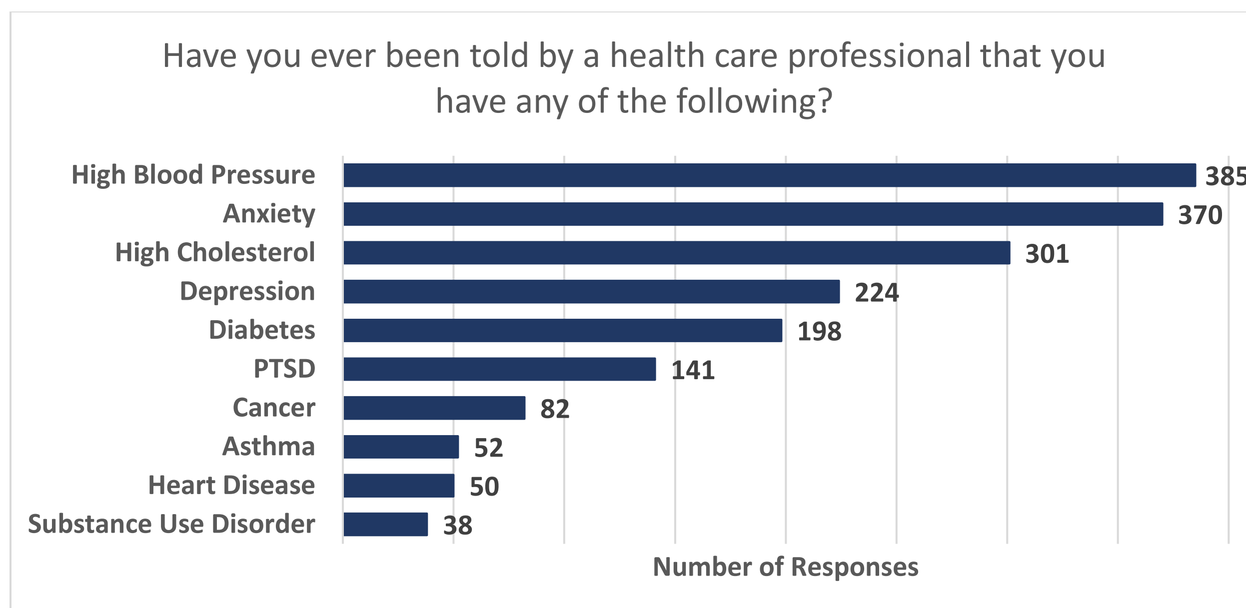
This key theme was not prioritized by the community; however, respondents shared there is a lack of specialists in Southern Oregon, leading to long wait lists to be seen. There is a particularly critical shortage in the areas of endocrinology, rheumatology, and neurology. Additionally, as a result of the COVID-19 pandemic many people have either delayed care or gone without seeking medical treatment, which has caused their conditions to worsen and their health to decline.

"Having an improved system of care where everything like a whole person is addressed, and having a better way to communicate with each other, I think would be incredibly helpful."
–Community Stakeholder

Survey Data

Overall, most respondents reported a chronic condition that would likely benefit from a specialist, such as an oncologist, cardiologist, pulmonologist, or endocrinologist. Mental health concerns also ranked highly, with respondents citing a combined 78% for anxiety, depression, and/or PTSD. Results for Spanish-speaking respondents were similar, with mental health (79%), diabetes (36%), and asthma (15%) the most reported chronic health issues that would benefit from specialty care.

Figure 37. Number of Survey Respondents Reporting Chronic Conditions

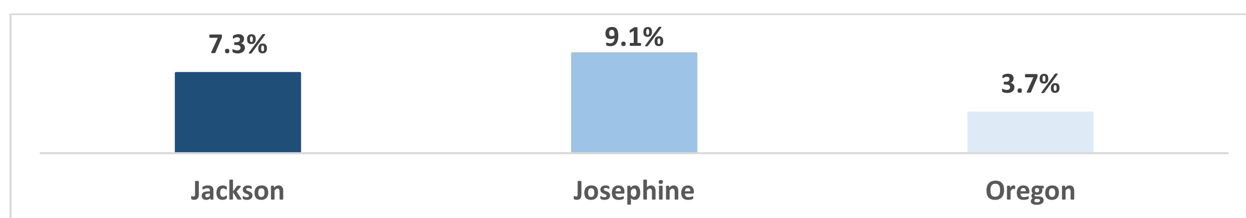


DATA SOURCE: Community Health Needs Assessment, 2022

Secondary Data

Heart disease is the leading cause of death for both men and women. Coronary heart disease (CHD) is the most common type of heart disease, killing over 370,000 people annually. Heart disease is the leading cause of death for people of most ethnicities in the US, including African Americans, Hispanics, and whites. For American Indians or Alaska Natives or Pacific Islanders, heart disease is second only to cancer. Jackson and Josephine counties report significantly higher rates of heart disease than the rest of Oregon.

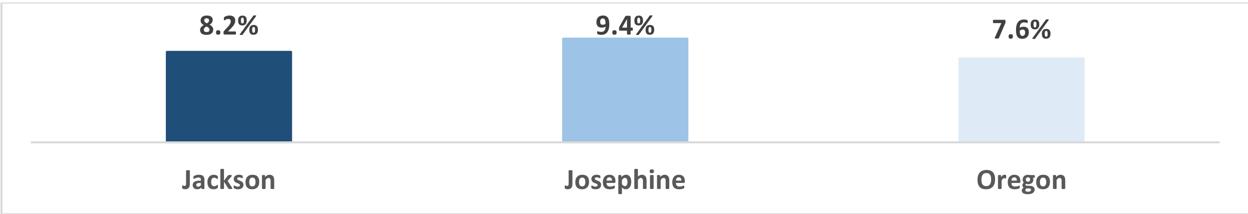
Figure 38. Coronary Heart Disease Crude Prevalence, by County and State, 2019



DATA SOURCE: Providence Data Hub, Behavioral Risk Factor Surveillance System Survey (BRFSS), 2019

Continued advances in cancer research, detection, and treatment have resulted in a decline in both incidence and death rates for all cancers from 1975-2006. Among people who develop cancer, more than half will be alive in 5 years. Yet, cancer remains a leading cause of death in the United States, second only to heart disease. Non-skin-cancer diagnoses in Jackson and Josephine counties exceed Oregon rates.

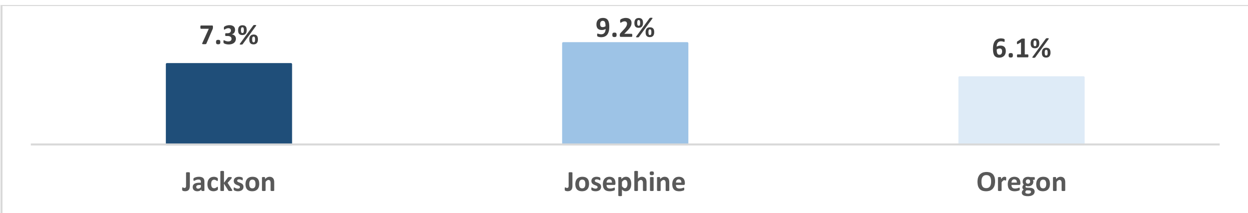
Figure 39. Cancer Crude Prevalence (Excludes Skin Cancers), by County and State, 2019



DATA SOURCE: Providence Data Hub, Behavioral Risk Factor Surveillance System Survey (BRFSS), 2019

In 2011, 6.3% (15 million) of adults aged≥18 years reported that they had COPD nationwide. Another estimated 15 million adults have impaired pulmonary function and COPD symptoms but are unaware of having COPD because the disease has not been diagnosed by their physician with the use of spirometry Approximately 80%–90% of identified COPD cases occur at ages≥45 years. Almost 80% of COPD deaths are attributable to smoking; other risk factors for COPD include occupational exposure, ambient air pollution, and long-term severe asthma. COPD diagnoses in Jackson and Josephine counties exceed state averages.

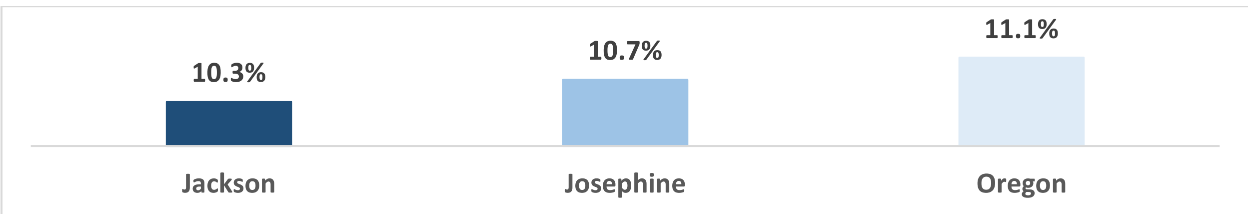
Figure 40. COPD Crude Prevalence, by County and State, 2019



DATA SOURCE: Providence Data Hub, Behavioral Risk Factor Surveillance System Survey (BRFSS), 2019

While Jackson and Josephine counties show lower percentages compared to the rest of Oregon, community members exhibiting asthma have a higher likelihood of adverse outcomes including emergency department visits, hospitalizations, and death. Compared with persons without asthma, persons with asthma have more days of activity limitation and missed school and missed work and are more likely to report comorbid depression.

Figure 41. Asthma Crude Prevalence, by County and State, 2019

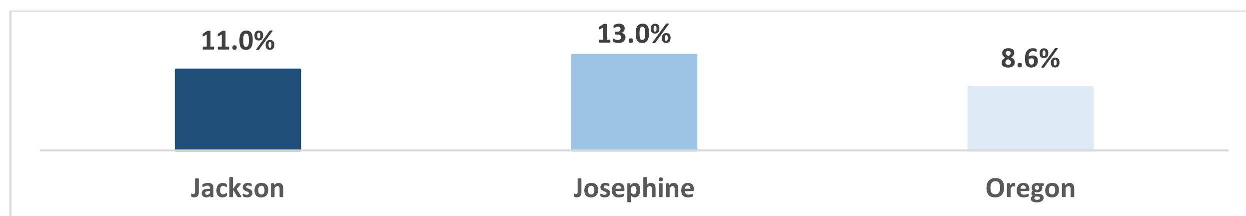


DATA SOURCE: Providence Data Hub, Behavioral Risk Factor Surveillance System Survey (BRFSS), 2019

The impact of diabetes has increased with the increasing prevalence of obesity. Substantial differences in diabetes prevalence exist by age, race, and ethnicity. Multiple long-term complications of diabetes can be prevented through improved patient education and self-management and provision of adequate

and timely screening services and medical care. Jackson and Josephine Counties showed a significantly higher incidence of diabetes compared to elsewhere in Oregon.

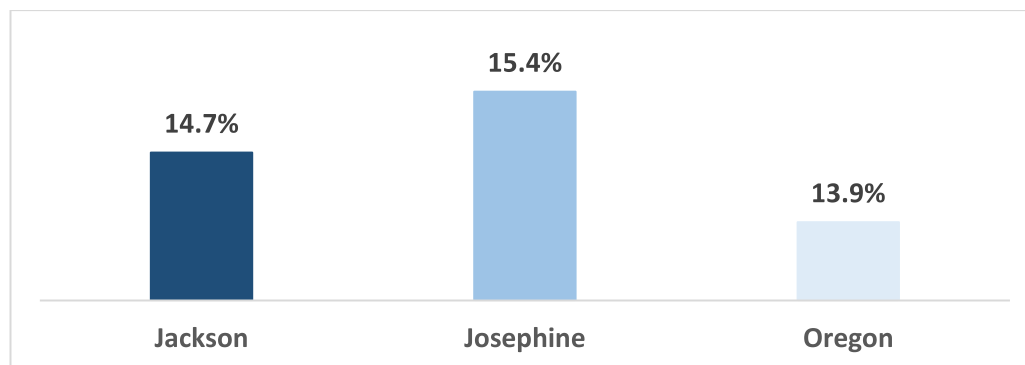
Figure 42. Diabetes Crude Prevalence, by County and State, 2019



DATA SOURCE: Providence Data Hub, Behavioral Risk Factor Surveillance System Survey (BRFSS), 2019

Only about 17% of US adults are considered to be in a state of optimal mental health. While Jackson and Josephine County only trend slightly higher than the state for self-reported mental health issues, it is important to note the lasting impact poor mental health can have on physical health and chronic disease. Evidence has shown that mental disorders, especially depressive disorders, are strongly related to the occurrence, successful treatment, and course of many chronic diseases including diabetes, cancer, cardiovascular disease, asthma, and obesity and many risk behaviors for chronic disease; such as, physical inactivity, smoking, excessive drinking, and insufficient sleep.

Figure 43. Frequent Mental Health Crude Prevalence, by County and State, 2019



DATA SOURCE: Providence Data Hub, Behavioral Risk Factor Surveillance System Survey (BRFSS), 2019

EXISTING ASSETS AND RESOURCES

Below is a list of community resources addressing mental health in Jackson and Josephine counties:

- Adapt
- Addictions Recovery Center
- Columbia Care Services
- Compass House
- Crisis Resolution Center
- Family Solutions
- Hope Village
- Integrative Health Center at Rogue Community Health

- Jackson County Health & Human Services Crisis Hotline
- Jackson County Mental Health
- Kairos
- La Clinica
- Maslow Project
- OnTrack Rogue Valley
- Options for Southern Oregon
- Rogue Retreat
- Southern Oregon Veterans Rehabilitation Center & Clinics

Below is a list of community resources that may assist with managing chronic conditions:

- AllCare
- Jackson Care Connect
- La Clinica
- Oregon Wellness Network
- Rogue Community Health
- Siskiyou Community Health

Note: This list of assets was provided by assessment participants and stakeholders. It is not meant to be an exhaustive list of all resources available. Also, note some resources are available in either Jackson or Josephine County only, and some in both counties

Next Steps

The 2022 community health needs assessment of Jackson and Josephine Counties serves multiple purposes. Among these purposes, the assessment enables Asante and Providence to:

- Investigate current health status, health priorities, and new and emerging concerns among Jackson and Josephine County community members and service providers
- Identify the social determinants of health most affecting our region and explore how these factors are impacting overall health and vitality of our communities
- Hear individual and group voices from a broad cross-section of the community to develop a deeper understanding of current and emerging health issues
- Observe the shifting patterns of these health issues over time in Jackson and Josephine Counties
- Identify assets and resources as well as gaps and needs in services in order to help set funding and programming priorities
- Fulfill the CHNA requirements for Asante and Providence Hospitals
- Use the data gathered to inform and involve our community partners and community members in the community health improvement process

This assessment lays the foundation for the Community Health Improvement Plans (CHIPs) that will be developed for Asante Ashland Community Hospital, Asante Rogue Regional Medical Center, Asante Three Rivers Medical Center and Providence Medford Medical Center in fiscal year 2023. The quantitative and qualitative data presented in this report and the priority community health needs identified can guide the development of goals, objectives, strategies, and performance measures. Each hospital will engage in their own processes to further evaluate this work and identify objectives and strategies they will engage in over the next three-year cycle toward meaningful positive impact.

SIGNIFICANT HEALTH NEEDS

Prioritization Process and Criteria

Through a collaborative process of data collection, analyzing community input, and cross referencing qualitative and quantitative data, Providence and Asante identified the following key themes: homelessness and housing instability, mental health, substance use/misuse challenges, access to health care services, affordable childcare and preschools, economic insecurity, and chronic conditions. Referencing these key themes, Providence and Asante separately selected priority health needs.

By engaging the Medford Service Area Advisory Council, council members representing internal Providence staff and community members selected the top four priority needs through an anonymous voting system. Prior to voting, the Council received a summary document of key data points and highlights from the CHNA process. After attending a presentation of overall CHNA methods, processes, and findings, the Council engaged in a robust discussion of the findings in preparation to vote on the service area's priority needs.

The Council considered the following criteria when going through the prioritization process:

- Worsening trends over time.
- Disproportionate impact on low-income and/or Black, Brown, Indigenous, and People of Color (BBIPOC) communities.
- Service area rates worse than state average and/or national benchmarks.
- Opportunity to impact: organizational commitment, partnership, severity, and/or scale of need.
- Alignment with existing health system priorities.

2022 Priority Needs

Considering PMMC's unique capabilities, community partnerships, and potential areas of collaborative community impact, we are committed to addressing the following priorities as aligned with the collaborative priority areas:

Mental Health and Substance Use Disorder: focus on prevention and treatment, social isolation, and community building related to communal spaces and recreation. This priority area refers to the growing challenges of accessing care due to workforce shortages, a lack of culturally responsive care, and affordability.

Health Related Social Needs: focus on housing stability, navigation of supportive services, food insecurity, and transportation. This priority area refers to the unmet social needs that exacerbate poor health and quality of life outcomes.

Economic Security: focus on affordable childcare, education, and workforce development. This priority area affects nearly every aspect of a person's life and refers to the challenge of affording basic living expenses and obtaining affordable education.

Access to Care and Services: focus on chronic disease management and prevention, oral health, and virtual care. This priority area refers to the lack of timely access to care and services due to, among others, physical, geographic, and systemic limitations.

At the conclusion of the assessment process, there were three cross-cutting themes that consistently surfaced and that affect all four priority areas:

- Racism, discrimination, and inclusion
- Culturally responsive care and services
- Trauma informed care and services

Potential Resources Available to Address Significant Health Needs

Understanding the potential resources to address significant health needs is fundamental to determining current state capacity and gaps. The organized health care delivery systems include Jackson and Josephine County Departments of Public Health, Asante Rogue Regional Medical Center, Asante Three Rivers Medical Center, Asante Ashland Community Hospital, and Providence Medford Medical Center. In addition, there are numerous social service community-based agencies, faith-based organizations, and private and public-school systems that contribute resources to address these identified needs. See Appendix 4 for a list of potentially available resources available to address significant health needs.

EVALUATION OF 2019-2021 CHIP IMPACT

This report evaluates the impact of the 2020-2022 Community Health Improvement Plan (CHIP). Providence responded to community needs by making investments of direct funding, time, and resources to internal and external programs dedicated to addressing the previously prioritized needs using evidence-based and leading practices.

Table 1. Outcomes from 2020-2022 CHIP

Priority Need	Program or Service Name	Program or Service Description	Results/Outcomes
Chronic Conditions	Providence Diabetes Prevention Program	Provide Diabetes Prevention Program cohorts to Jackson County residents.	Due to the COVID-19 pandemic, DPP sessions were held virtually: 2020 - 6 cohorts 2021- 7 cohorts 2022 Data N/A
	Addressing Diabetes in the Latinx Community	Partner with La Clinica to close the health equity gap for Latinx patients living with diabetes compared to their non-Latinx counterparts.	1,081 individuals served (Jan-Mar 2022)
Access to Care/Oral Health	Medical Teams International Free Mobile Dental Clinics	Partnering with Medical Teams International and St. Vincent de Paul to provide free emergency dental services to uninsured/underinsured community members.	2020 - 7 clinics 2021 – 4 clinics 2022 Data N/A
Behavioral Health/Substance Use Disorders	Providence Community Resource Desk	Connect Jackson County residents with behavioral health and substance use disorder (SUD) resources through the Providence Community Resource Desk	59 individuals connected to behavioral health and SUD resources in 2020
	Integrated Behavioral Health Model	Partner with La Clinica to integrate behavioral health	4,332 individuals served

		screening and treatment into a primary care model	
	Substance Use Disorder Treatment	Partner with Addictions Recovery Center to provide access to individuals seeking treatment for substance use and co-occurring mental health disorders.	2020- 1,733 individuals received assessments
	Therapy for Youth Experiencing Homelessness	Partner with the Maslow Project to provide therapy to adolescents in crisis	2022 Data N/A
	Wellness Program and Skill Building	Partner with Compass House to support community members living with mental health challenges as they build workplace skills, confidence, self-esteem, and healthy relationships.	2022 Data N/A
	Suicide Prevention	Partner with the United Way to prevent suicide through three community-based efforts focused on mental wellness and removing stigma	2022 Data N/A
Social Determinants of Health and Wellbeing – Housing	Chronically Homeless Outreach Partnership	Partner with the City of Medford to provide transitional housing and case management services to individuals experiencing chronic homelessness.	14 individuals served (this is less than expected due to the COVID-19 pandemic)
	Kelly Shelter	Partner with Rogue Retreat to provide year-round emergency shelter to individuals experiencing homelessness.	380 individuals served
	Project Turnkey	Partner with the City of Medford to provide temporary housing and low-level support for individuals experiencing homelessness post hospital discharge	Four rooms fully renovated up to ADA standards
	Rent and Utility Assistance	Partner with St. Vincent de Paul to prevent homelessness by providing rent and utility assistance	2021 – 40 persons served so far, second report due 7/22 2022 Data N/A

	Urban Campground	Partner with Rogue Retreat to provide temporary shelter and case management services to individuals experiencing homelessness	1,025 persons served
	Capacity Building	Support Rogue Retreat to increase efficiency and capacity to serve more community members who are experiencing homelessness	2022 Data N/A
	Emergency Transitional Housing	Partner with ACCESS to provide emergency transitional housing to vulnerable unsheltered individuals and families	2022 Data N/A
Social Determinants of Health and Wellbeing – Food Insecurity	Providence Community Resource Desk	Partner with ACCESS to provide resources to food insecure households through the Providence Community Resource Desk	113 individuals connected with food resources in 2020
	Farm to Families Produce Box Program	Partner with Rogue Valley Farm to School to provide boxes and fresh produce and pantry staples to families in the Phoenix/Talen School District	Weekly produce boxes were provided to 150-200 households for 12 weeks

Table 2. Key Informant Survey Responses

Nineteen key informants from a variety of community organizations provided feedback on Providence Medford Medical Center's (PMMC) efforts to address four priorities identified in the PMMC 2020-2022 Community Health Improvement Plan (CHIP). Below is a table summarizing the key informant's feedback on PMMC's efforts to address Access to Care/Oral Health, Behavioral Health/Substance Use Disorders, Chronic Conditions, and Social Determinants of Health (specifically Housing and Food Insecurity). See Appendix 2 for the full Key Informant Survey Results.

2020-2022 CHIP Priorities	Poor	Fair	Good	Very Good	Excellent
Access to Care/Oral Health	0%	0%	63%	26%	11%
Behavioral Health/Substance Use Disorders	5%	32%	42%	16%	5%

Chronic Conditions	0%	0%	74%	21%	5%
Social Determinants of Health (Housing and Food Insecurity)	0%	5%	79%	11%	5%

Addressing Identified Needs

Asante and Providence will develop individualized Community Health Improvement Plans (CHIP) for each hospital within the Jackson and Josephine County service areas. Each hospital will address the prioritized health needs identified in this CHNA and develop strategies to improve access to resources, community capacity, and core competencies. Those strategies will be documented in a CHIP, describing how Asante and Providence plans to address their respective prioritized needs. If a hospital does not intend to address a need or plans to have limited response to the identified need, the CHIP will explain why. The CHIP will not only describe the actions each hospital intends to take, but also the anticipated impact of these actions and the resources the hospital plans to commit to address the health need.

Because partnership is important when addressing health needs, the CHIP will describe any planned collaboration between Asante, Providence, and community-based organizations in addressing the prioritized needs. The CHIP will be approved and made publicly available no later than February 15, 2023, for Asante and May 15, 2023, for Providence.

APPENDICES

Appendix 1: Community Input

INTRODUCTION

Asante and Providence contracted with the Rede Group to conduct stakeholder interviews and community listening sessions. Listening to and engaging with the people who live and work in the community is a crucial component of the CHNA, as these individuals have firsthand knowledge of the needs and strengths of the community. The Rede Group conducted 10 stakeholder interviews including 12 participants, people who are invested in the well-being of the community and have first-hand knowledge of community needs and strengths. They also conducted five listening sessions. The goal of the interviews and listening sessions was to identify what needs are currently not being met in the community and what assets could be leveraged to address these needs.

METHODOLOGY

Selection

The Rede Group completed five listening sessions that included a total of 68 participants. The sessions took place between January 11 and February 10, 2022.

Community Input

Community Input Type and Population	Location of Session	Date	Language
Listening session with individuals with a diagnosis of a mental health condition	Compass House (with facilitator and notetakers virtual)	1/11/2022	English
Listening session with farm workers and clients of Únete	Únete and virtually on Zoom	1/20/2022	Spanish
Listening sessions with individuals from the YMCA	Zoom	1/20/2022	English
Listening session with individuals experiencing homelessness	Rogue Retreat	1/21/2022	English
Listening session with parents of young children (5 years or younger)	Zoom	2/10/2022	English

The Rede Group conducted 10 stakeholder interviews including 12 participants overall in January and February 2022. Stakeholders were selected based on their knowledge of the community and engagement in work that directly serves people who are economically poor and vulnerable. Asante and Providence aimed to engage stakeholders from social service agencies, health care, education, housing, and government, among others, to ensure a wide range of perspectives. Included in the interviews was the Program Manager for Communicable Disease and Epidemiology Data and Performance from Jackson County Public Health.

Key Community Stakeholder Participants

Organization	Name	Title	Sector

Organization	Name	Title	Sector
Addictions Recovery Center, Inc. (ARC)	Lori Paris	President and CEO	Substance use disorders and mental health
Ashland Police Department	Tighe O'Meara	Police chief	Law enforcement
Grants Pass Police Department	Warren Hensman	Police chief	
Jackson County Public Health	Andrea Krause	Program manager for Communicable Disease and Epidemiology Data and Performance	Public health, communicable diseases
La Clínica	Maria Ramos Underwood	Chief development officer	Health care, community health
Maslow Project	Fallon Stewart	Program supervisor of School Based Services	Homelessness
Rogue Retreat	Chad McComas	Executive director	Homelessness
Rogue Valley Council of Governments	Constance Wilkerson	Senior and Disability Services director	Senior and disability services, transportation planning, land use planning, community development, natural resources
Rogue Valley Transportation District	Paige West	Planning and Strategic Programs manager	Transportation, accessibility services
	Tim Fountain	Accessible Transportation manager	
United Community Action Network (UCAN)	Kelly Wessels	Chief operating officer	Social service provider, community action agency, antipoverty services
United Way of Jackson County	Dee Anne Everson	CEO/executive director	Social service provider, including education, health, financial stability, and transportation

Facilitation Guides

For the listening sessions, participants were asked an icebreaker and three questions (see Listening Session Questions for the full list of questions):

- Community members definition of health and well-being.
- The community needs.
- The community strengths.

For the stakeholder interviews, Providence developed a facilitation guide that was used across all hospitals completing their 2022 CHNAs (see Stakeholder Interview Questions for the full list of questions):

- The community served by the stakeholder's organization.
- The community strengths.
- Prioritization of unmet health related needs in the community, including social determinants of health.
- The COVID-19 pandemic's effects on community needs.
- Suggestions for how to leverage community strengths to address community needs.
- Successful community health initiatives and programs.
- Opportunities for collaboration between organizations.

Training

The facilitation guides provided instructions on how to conduct a stakeholder interview and listening session, including basic language on framing the purpose sessions. Facilitators participated in trainings on how to successfully facilitate a stakeholder interview and listening session and were provided question guides.

Data Collection

Stakeholder interviews were conducted virtually and recorded with the participant's permission. Two note takers documented the listening session conversations.

Analysis

Qualitative data analysis was conducted by Providence using Atlas.ti, a qualitative data analysis software. The data were coded into themes, which allowed the grouping of similar ideas across the interviews, while preserving the individual voice.

The recorded interviews were sent to a third party for transcription. The analyst listened to all audio files to ensure accurate transcription. The stakeholder names were removed from the files and assigned a number to reduce the potential for coding bias. The files were imported into Atlas.ti. The analyst read through the notes and developed a preliminary list of codes, or common topics that were mentioned multiple times. These codes represent themes from the dataset and help organize the notes into smaller pieces of information that can be rearranged to tell a story. The analyst developed a definition for each code which explained what information would be included in that code. The analyst coded eight domains relating to the topics of the questions: 1) name, title, and organization of stakeholder; 2) population served by organization; 3) greatest community strength and opportunities to leverage these strengths; 4) unmet health-related needs; 5) disproportionately affected population; 6) effects of COVID-19; 7) successful programs and initiatives; and 8) opportunities to work together.

The analyst then coded the information line by line. All information was coded, and new codes were created as necessary. All quotations, or other discrete information from the notes, were coded with a domain and a theme. Codes were then refined to better represent the information. Codes with only one or two quotations were coded as "other," and similar codes were groups together into the same category. The analyst reviewed the code definitions and revised as necessary to best represent the information included in the code.

The analyst determined the frequency each code was applied to the dataset, highlighting which codes were mentioned most frequently. The analyst used the query tool and the co-occurrence table to better

understand which codes were used frequently together. For example, the code "food insecurity" can occur often with the code "obesity." Codes for unmet health-related needs were cross-referenced with the domains to better understand the populations most affected by a certain unmet health-related need. The analyst documented patterns from the dataset related to the frequency of codes and codes that were typically used together.

This process was repeated for the listening sessions, although rather than recordings, notes were used. The analyst coded three domains related to the topics of the questions: 1) vision; 2) needs; and 3) strengths.

FINDINGS FROM COMMUNITY LISTENING SESSIONS

Vision of a Health Community

Listening session participants were asked to share their vision of a health community. The following themes emerged:

- **Social connection and support:** The primary theme shared was that in a healthy community people are connected and helping one another. They noted this has been especially true during the pandemic and emphasized everyone should be taken care of in a healthy community, including older adults, people with physical or mental illness, and people experiencing homelessness. They noted that people should receive the help they need and also have the opportunity to help others through volunteering. They shared people come together in challenging times, like after the wildfires in 2020 and during the COVID-19 pandemic.

  "One thing I really like about the community is when something happens like a pandemic or fire, everyone comes together and makes sure people have what they need, like groceries"—Community Member

- **Resources to meet people's needs**: Many participants spoke to healthy communities having resources to address people's needs and people have access to those resources. They shared a healthy community has resources related to jobs, housing, mental health, health care, and transportation. People know about these resources and can easily utilize them.
- **Diversity and inclusion:** A healthy community is diverse and welcoming. In a healthy community everyone is respected and accepted and treated with dignity. Participants noted the importance of being connected to people with different experiences.

  "Everyone is treated with respect and dignity."—Community Member

- **Education and employment opportunities**: Community members noted the importance of educational opportunities for kids, including preschool. They also shared in a healthy community people have access to employment opportunities.
- **Affordable housing and economic security**: Participants shared that in a healthy community everyone is sheltered and can afford to meet their basic needs, like paying for housing, bills, and food. They noted that housing should match the pay scale of the community.

“People having roofs over their heads is a sign of a healthy community.”—Community Member

- **Safety**: In a healthy community people feel safe and kids are able to play safely outside.

Community Needs

- **Access to health care services:** This was the most common need mentioned and included needing more affordable medical care and more health care providers in general to ease access. They shared a need for financial assistance to ensure people can afford health services and medications, as well as health insurance support for people without insurance (specifically people who are undocumented or those with an income slightly above the Medicaid threshold who cannot afford to purchase their own insurance). Participants also noted the importance of culturally responsive medical care and resources for the LGBTQIA+ community.
- **Homelessness and housing:** This need was also frequently discussed. Participants shared a need for more affordable housing, particularly after the Almeda fire in 2020, as well as more transitional and supportive housing. They emphasized concern for neighbors experiencing homelessness and shared a need for more homeless resources, hygiene facilities and restrooms, and mental health support. They also shared people who are formerly incarcerated may experience increased barriers to accessing housing.
- **Mental health:** Participants noted a need for more mental health services, including counselors and peer support specialists. They saw a need for more awareness and education around mental health to reduce stigma. They would specifically like to see more support groups, especially for new and isolated parents, and more trauma-informed care, especially for law enforcement.
- **Substance use:** Participants shared a need for more substance use disorder (SUD) treatment facilities and improved staffing of current treatment centers. They perceive that substance use/misuse is increasing in the community and see a need to ensure people can afford to access needed treatment.
- **Economic security:** Participants discussed that employment is very important for ensuring that people can access housing and afford needed care. They noted there should be more services to help people pay for housing and other bills. They also noted people who are formerly incarcerated may experience more barriers to employment.
- **Easy access to and coordination of community resources**: Participants would like to see one location where all community resources are highlighted, with information about who the resources serve and how to access them. They would also like to see better connection between the different community resources and more referrals.
- **Childcare:** Participants shared childcare is very expensive and hard to access.

“Our daycare exceeds our mortgage. The current model for this can’t survive.”—Community Member

- **Safe and accessible parks and recreation**. Participants would like to see more play spaces and recreational opportunities, as well as free indoor spaces for families to play in the winter.

- **Community building and anti-racism:** Participants shared a need to address racism and discrimination in the community and ensure everyone feels welcome. They would like to see more safe spaces where people can come together and get to know one another.

Community Strengths

The following table includes programs, initiatives, or other resources that members noted are working well for them.

Area of Need	Program, Initiative, or Other Resource
Access to health care	Jackson Care Connect CCO *"Jackson Care Connect is awesome - they provide a partnership benefit to their members to participate in the YMCA. Jackson Care Connect gets involved when there are mental health needs. I think very highly of their model, trying to keep people out of doctors' offices and prevent preventable health problems. They are a great resource for our community."—Community Member* La Clínica Mercy Flights
Aging support	Oregon Care Partners
Community resources	Community Resource Fair Libraries Rogue Valley Family YMCA *"The YMCA has a lot of programs, and they accept EBT. They also have washers and showers we can use. They have a lot to offer."—Community Member*
COVID-19 response	Access to virtual services
Education	The schools and teachers, including school gardens *"During Covid, we've had some great teachers. They've had to work through a lot."—Community Member*
Farm workers and immigrant rights	Únete
Food security	Rogue Valley Farm to School produce box program Summer lunch program
Housing and homelessness	Hotels as temporary housing for people experiencing homelessness Maslow Project Rogue Retreat, including the Urban Campground and the Kelly Shelter

Mental health	988 (alternate phone number for people in mental health crisis) Compass House *"I can come to Compass House on my worst day and on my best day—no one will treat me differently; this is a safe place."—Community Member* Jackson County Crisis
Recreation	Jackson County parks and bike lanes Mt. Ashland Rogue Rock Gym Rogue Valley hiking trails and water areas for fishing
Social connections and support	Asante Ashland Community Hospital Family Birth Center's new parents support group Facebook groups for parents Kaleidoscope Play & Learn Groups
Substance use/misuse challenges	Addictions Recovery Center (ARC) Alcoholics Anonymous and Narcotics Anonymous support groups Oasis Center of the Rogue Valley On Track Rogue Valley Recovery Café
Transportation	Valley Lift with the Rogue Valley Transportation District

FINDINGS FROM STAKEHOLDER INTERVIEWS

Community Strengths

The interviewer asked stakeholders to share one of the strengths they see in the community and discuss how we can leverage these community strengths to address community needs. This is an important question because all communities have strengths. While a CHNA is primarily used to identify gaps in services and challenges, we also want to ensure that we highlight and leverage the community strengths that already exist. The following strengths emerged as themes:

Strong Community Partnerships to Meet Needs

The primary strength shared was "strong community partnerships." These strong partnerships are between nonprofits, health care, school districts, faith-based organizations, community and civic groups, and social support organizations, all working together to address community needs. They described the local organizations as working well together and prioritizing partnering and collaborating rather than competing. The COVID-19 pandemic has spurred more communication that has been made easier with virtual meetings.

Stakeholders described strong reliance on community partnerships that have been important in times of crisis, particularly in response to COVID-19 and wildfires. These partnerships have allowed emergency response activities to deploy quickly.

> *"I think it is the network of partnerships that allow innovative processes to be implemented quickly. In this community, it's relatively unique, in my experience, that we're able to deploy ideas into action more expediently."—Community Stakeholder*

Stakeholders recommended leveraging this strength to address some of the larger community needs, including homelessness and behavioral health challenges. They noted a lot of interest in serving the houseless population and wanting to work together to meet needs in Jackson and Josephine counties.

To leverage the strong stakeholder support, participants suggested building upon and investing in the work that local nonprofits are already doing. Additionally, finding ways to align and join together on services is important for making progress on community needs.

> *"Don't recreate the wheel. I think there are—I would invest in the nonprofits who are already designed and have documented experience serving the most underserved communities. There's a great group of folks in this community providing those services, and I think the best thing to do is go to them and say, 'What can we do to help you get to the next level?'"—Community Stakeholder*

Robust Network of Health-Related Services and Resources

Stakeholders identified the variety of health care and social service organizations as a community strength. Specifically, they noted a variety of health care and behavioral health resources that support accessing care. The Coordinated Care Organizations in particular offer a lot of programs and resources to address social determinants of health.

Stakeholders suggested leveraging this strength by finding more ways to collaborate and to prioritize offering preventive care.

> *"We need to be able to collaborate as a community to create the space we need to deliver services to people and sometimes competition and fundraising and whatever get in the way of that."—Community Stakeholder*

Stakeholders also suggested ensuring that these services meet community members where they are, rather than always requiring people to travel to a clinic or office, as this could help build trust and ease access.

Resilient and Engaged Community Members

Stakeholders emphasized community resilience as a strength, particularly after the Alameda and South Obenchain Fires in 2020. They noted that the community came together to rebuild and collaborate to address the resulting needs. They described an energetic community, willing to pull together to respond in times of challenge. Additionally, the COVID-19 pandemic has been another challenge that has led to community engagement and collaboration.

High Priority Unmet Health-Related Needs

Stakeholders were asked to identify their top five health-related needs in the community. One need was prioritized by almost every stakeholder and with high priority. Five additional needs were categorized as medium priority. The effects of the COVID-19 pandemic will be woven throughout the following sections on health-related needs.

Across the board, stakeholders were most concerned about the following health-related need:

- Homelessness and housing instability

Homelessness and housing instability

Homelessness and housing instability were overwhelmingly identified as the highest priority needs by stakeholders. They emphasized the importance of the entire community working together to address homelessness, noting it will take more than a few agencies to make a difference.

Stakeholders spoke to the connection between safe, affordable housing and many other needs, including physical and mental health care. Stakeholders discussed the importance of Housing First, meaning prioritizing providing permanent housing as quickly as possible to people experiencing homelessness, and other supportive services afterward. They emphasized this approach because people need to first be safe and have their basic needs met before they can address their physical and behavioral health needs.

> *"Safe housing at the beginning of their journey to recovery and safe housing coming out of treatment is essential. If they're returning to the street or to unsafe housing, where there is other drugs and alcohol use, then it's a vicious circle. I would say that that's the biggest one."—Community Stakeholder*

Stakeholders described a "desperate" need for housing in Josephine and Jackson counties, noting a general lack of shelters, transitional housing, permanent housing, etc.

> *"Our most desperate need is housing, by far, and across the spectrum in terms of housing, so everything from emergency shelter to transitional housing, to permanent housing, to workforce housing, and to housing for employees who are management and above. We're in an absolute housing crisis."—Community Stakeholder*

Numerous stakeholders discussed how the Almeda and Obenchain fires in 2020 contributed to the current housing challenges. They shared that not everyone who lost their home in 2020 has found permanent housing.

> *"We already had a severe housing shortage before the big fires here. We lost most of our affordable housing. In a pandemic time, that made things much worse."—Community Stakeholder*

Over 2,500 units were destroyed, as well as many RV and mobile home parks where seasonal farmworkers and older adults lived. Homes rebuilt in these fire-affected areas have been less affordable, displacing the communities that were previously living there.

“That is where I really want to push to up the inventory of affordable, accessible, safe housing for older adults and people with disabilities and migrant communities. I want everyone to be able to live in the communities they were enjoying before the wildfires.”—Community Stakeholder

Stakeholders identified older adults, the Latino/a community, and people with low incomes as particularly affected by the housing challenges as a result of wildfires.

Stakeholders suggested more investment in long-term shelter, rather than emergency shelter, as these are only temporary solutions that do not provide enough time for people to stabilize. They also noted the need for more homeless services, including warming/cooling shelters and hygiene services. While there are some warming and cooling shelters, the rotating location is challenging for people without transportation or who have to move all their belongings. Lack of hygiene services, such as places for people to shower, makes self-care difficult. Stakeholders spoke to wound care as a big need for people experiencing homelessness, exacerbated by the lack of hygiene services.

Related to health care, stakeholders spoke to a need for respite options for people recently discharged from the hospital without a safe place to stay. This is one place where health care systems need to be actively engaged in solutions.

Stakeholders identified Josephine County as having fewer support services for people experiencing homelessness, although there is a lot of effort to address these needs. Josephine County does not have a family shelter. There are more services located in Jackson County, particularly in Medford. Folks in rural parts of the counties may experience more barriers to accessing support services because of transportation and technology barriers.

Barriers to addressing homelessness and housing instability in Southern Oregon include the following:

- High cost of housing coupled with low wages or public benefits: Stakeholders’ primary concern was that jobs are not paying folks enough to meet the cost of living. Some people are paying close to 80 or 90% of their income on rent. For older adults receiving Social Security benefits, their fixed income may not be sufficient to afford the cost of rent. Stakeholders specifically noted the very high cost of housing in Ashland and most of Jackson County. This can mean that one costly event can lead people to lose their housing or become unsheltered.

  “With the rate of our housing costs, we don't have jobs that match that cost. Even right now with the jobs that are being paid, you would have to make almost twice as much to be able to afford a two-bedroom house reasonably.”—Community Stakeholder

- Poor housing quality: Stakeholders shared they see multiple families living together in overcrowded housing or poor-quality housing with health concerns related to mold or infestations. This can affect mental and physical health. They suggested a need for more case management to identify these concerns and ensure families are safe and accessing support services.
- Lack of affordable housing stock: Stakeholders shared there is generally a lack of housing stock.

Stakeholders were particularly concerned about the following populations' housing stability:

- Older adults: This population was frequently mentioned as one with fewer support services and substantial need. Social Security benefits may not be sufficient to cover rent. Additionally, older adults on Medicare no longer qualify for Oregon Health Plan, meaning the Coordinated Care Organization funds for addressing housing needs are not available to them. Technology barriers may also prevent older adults from accessing support services. Many older adults were displaced from their homes as a result of the Almeda and Obenchain fires in 2020, an event that highlighted there are not many services or coordinated care available to this population. They noted a particular concern for older adult women.
- Adults with disabilities: Adults with both cognitive and physical disabilities need more affordable, and accessible housing. There is a particular lack of safe housing for folks with cognitive disabilities.
- Latino/a community and migrant and seasonal workers: Many of these communities were displaced as a result of the wildfires in 2020. Stakeholders emphasized the importance of culturally responsive services and bilingual staff to help support coordination of services.

While the eviction moratorium was positive for keeping people stably housed, many people's financial and housing security were put at risk by the COVID-19 pandemic.

> *"They were behind when COVID hit. Then it hit and they were just, they fell off a cliff because they were already just barely holding on. It jeopardized their housing; it jeopardized their transportation. It jeopardized their ability to go to the doctor. It jeopardized their ability to pay for services of any kind."—Community Stakeholder*

Medium Priority Unmet Health-Related Needs

Five additional needs were often prioritized by stakeholders:

- Mental health.
- Substance use disorders.
- Affordable childcare and preschools.
- Economic insecurity.
- Access to health care services.

Mental health

Mental health is connected to a variety of other needs, including substance use/misuse challenges, which can be co-occurring. Stakeholders shared mental health challenges can be a barrier for people accessing physical health care services and is connected to a person's overall well-being.

> *"Mental health, I think that that's been a widely recognized issue, especially as a dual need with substance abuse. It's a big thing in our area."—Community Stakeholder*

They identified addressing mental health as a very big need in the community and were concerned about the high suicide rate, specifically speaking to the rate in Jackson County. They spoke to needs

across the spectrum of care, including inpatient, outpatient, preventive, early intervention, and harm reduction.

Stakeholders discussed the following priorities for addressing community mental health needs:

- Crisis response services: This need was emphasized by many stakeholders. They shared there are very few options for a person experiencing a mental health crisis. A person experiencing homelessness in crisis may not be allowed to remain in a shelter if putting others at risk. They identified a need for professionally trained crisis intervention teams that can respond to and address folks in a mental health crisis. Often this role is put on police officers who are not trained to address this in an adequate manner. Often the only options are the emergency room or jail if a crime has been committed.
- More hospital beds for people in mental health crisis: The current number of mental health crisis beds typically fill up, meaning people have to wait in the emergency department.
- A Housing First approach: Stable housing is the first step to addressing mental health needs. There needs to be more supportive housing at different acuity levels, that honors people's privacy and dignity.
- Transportation: This can be a barrier to accessing care, particularly for older adults and people with disabilities.

Stakeholders were particularly concerned about the unmet mental health needs for the following populations:

- Older adults and adults with disabilities: Stakeholders were concerned that older adults and adults with disabilities may experience social isolation, particularly as a result of the pandemic. Adults of Medicare may also be limited in the mental health professionals their insurance may cover.
- People experiencing homelessness: Living unhoused can make addressing mental health needs more challenging.

Stakeholders were particularly concerned about how the COVID-19 pandemic has exacerbated mental health challenges. Particularly for older adults, they may be experiencing more social isolation, which can increase the likelihood of dementia progression. Many support groups are no longer gathering or only gathering virtually, making it challenging for people to connect.

Stakeholders spoke to seeing an increase in suicide-related calls and more mental health challenges.

Staffing shortages have also contributed to delayed or cancelled appointments, meaning people who are ready to get help but cannot access it right away, may not be ready to engage again for a while.

> *"With this particular population [with mental health needs], it's really taking advantage of that in the moment when they're willing to address it."—Community Stakeholder*

On a positive note, more people may be wanting to engage with a mental health professional as a result of the pandemic and the wildfires, which have contributed to normalizing asking for help.

Substance use/misuse challenges

Stakeholders identified substance use disorders (SUD) as an unmet community need, with many people not receiving the help they need. They shared they have seen it become more of an apparent issue in the community over the past few years. They discussed its connection to mental health challenges, noting the two can be co-occurring. They also shared that SUDs sometimes prevent people from accessing needed health care and raises concern for child abuse and neglect.

Stakeholders identified the following gaps in SUD-related services:

- Detox beds and inpatient SUD programs: Stakeholders shared there are a limited number of detox beds available and limited inpatient programs.

  “Largely across the board, there's very, very little detox or beds available for that for all ages. We definitely need more detox and more access to inpatient programs across the board but specifically for youth.”—Community Stakeholder

- Medication-Assisted Treatment (MAT) facility in Josephine County: Stakeholders shared there is a small MAT facility in Jackson County, but none in Josephine County. This means some people spend a couple of hours traveling to the MAT facility and can cause transportation barriers.

  “We don't have [a Medication-Assisted Treatment (MAT) facility] at all in Grants Pass. I think that's problematic because there are a lot of people that are trying to regain some portion of their life back that needs to step into the MAT world, so they can continue on their journey of recovery. We're lacking that big time here.”—Community Stakeholder

Some SUD treatment programs have closed in the community and low reimbursement models mean the system is generally underfunded.

Stakeholders identified the following barriers to addressing SUDs in Jackson and Josephine counties:

- Childcare: For people in recovery, reliable childcare is very important. For example, if people need to get to medical detox, they will need childcare, which is lacking in the area. Parents may not be able to participate in a residential treatment program without safe and reliable childcare.

  “What I would also tell you is that in early recovery, life is really complicated for people, especially for young parents with children, and trying to juggle all of the things that need to happen.”—Community Stakeholder

- Transportation: For patients receiving MAT, they may need to travel to Medford or another program, which can be a couple of hours of round-trip travel.
- Lack of qualified staff: Recruiting certified alcohol and drug counselors from outside the community can be challenging, meaning that having sufficient staffing to meet the community need is a barrier.
- Stigma: Stakeholders shared there is not always a lot of openness and comfort discussing substance use/misuse. They discussed the importance of recognizing a SUD as a health

condition rather than a bad choice or shortcoming. Patients with a SUD can experience stigma from health care providers as well.

"There are (sic) still a huge stigma for people suffering with substance use disorders. That people still have a belief that they're bad people and they made bad choices, and that is not the case. No one sets out to become addicted and to live in that life. That is just not true."—Community Stakeholder

The following populations may experience additional barriers to addressing SUDs:

- Older adults: Medicare does not cover SUD treatment, which means the system is underfunded and older adults may not be able to afford treatment they need.
- People experiencing homelessness: Housing instability makes addressing substance use more challenging. Stakeholders recommended implementing supportive housing at different acuity levels.
- Young people: There is no inpatient SUD treatment or detox for young people and limited outpatient.

For some people, increased social isolation as a result of the COVID-19 pandemic has exacerbated substance use challenges. In 2021, stakeholders spoke to seeing increases in overdose deaths. Staffing shortages have also led to delayed and cancelled appointments, meaning people who are ready to get help but cannot access it right away, may not be ready to engage again for a while.

Access to health care services

Stakeholders identified the following needs related to access to care:

- Specialists: They shared there are not a lot of specialists in the area, leading to long wait lists to be seen. There is a particularly critical shortage in Jackson County in the following areas: endocrinology, rheumatology, and neurology.
- Bilingual and bicultural providers: Stakeholders spoke to the need for more Spanish-speaking providers in particular and ensuring health education information is translated into Spanish.

"Language access [is] a really big need within the community. We have a large Hispanic, Latinx community. Getting resources available to them in Spanish, especially in a timely manner, I think a lot of organizations try, but they don't have the resources to have translation and other things available in the same way that they do for English. That creates a lot of need and disparity among that population."—Community Stakeholder

- Care coordination: While community organizations and Coordinated Care Organizations (CCOs) do provide a lot of care coordination for patients, there is still room for more support for people navigating the complexities of the health care system. This is particularly true for people who are living unsheltered, have transportation barriers, or primarily speak a language other than

English. It can take a lot of time and effort for people to access services because the system is not easy to navigate.

"I think even someone who works within the system, who's highly educated like myself, I can have trouble navigating different areas of the health or social service system or knowing how to send someone. I think someone who is already working, possibly, two jobs or other, information isn't clear. There's a lot of time and energy that needs to go into accessing resources."—Community Stakeholder

Stakeholders identified several barriers that can make accessing care more challenging:

- Transportation: The primary barrier to care identified by stakeholders was transportation. This is especially challenging for people living in rural areas and in Jackson County where the transit district does not cover the entire county and has limited hours. It can be challenging for people living in rural areas to get into urban areas for care, but also for people needing to travel to other parts of the state like Eugene or Portland for specialty care. Transportation can be more challenging for older adults and people living with a disability. It can also be challenging for veterans who need to get to the VA hospital in Roseburg because there is not consistent service. While there is non-emergency medical transit, it has a fixed route and boundary where it can pick up people. Therefore, people outside of this boundary are still limited. Cost of fare can also be a barrier, even for those with a subsidized pass. Stakeholders spoke to people canceling regular care, like dialysis, towards the end of the month when they run out of money for fair. Another barrier is time; it can take a lot of time to travel to appointments.

  "When you're disabled and you're on a fixed income and you fall between the cracks, because you don't qualify for Medicaid and other programs, you end up having to make those really tough decisions."—Community Stakeholder

  "I also just think part of that is the time involved. If it takes you an hour, two hours of your time to come somewhere and go back, that's a precious resource, especially for people who are working types of jobs that are more hourly based that don't have leave, that kind of thing. I think that that can be a real barrier just purely because of time even."—Community Stakeholder

- Cost of care: Even with charity care and insurance, not everyone is able to afford the deductible or cost of care. Stakeholders spoke to seeing people run into situations where their treatment will not be continued unless the patient can make a payment, meaning people are not getting needed care.

  "We need to get past this notion that we can't provide healthcare for free. For some groups, we absolutely have to provide healthcare for free of costs. Affordability is the big issue."—Community Stakeholder

The following populations may experience additional barriers to care:

- People experiencing homelessness: Stakeholders were particularly concerned about access to health care services for people living unsheltered. Many discussed a need for recuperative care for people experiencing homelessness once they have been discharged and called on health care to help bridge this gap in service. They also noted a lack of wound care and triage for folks living unsheltered to address minor needs before they become emergencies. There is a need for greater understanding within health care regarding the barriers people living unsheltered may experience in following health care instructions and managing their hygiene without hygiene services.

  "Hygiene in our areas because we don't have shelters and things like that. We also don't have places for people to practice basic hygiene as far as showering and things like that. The impacts of that on wound care is just astronomical. It causes a revolving door in healthcare."—Community Stakeholder

- People identifying as LGBTQIA+: Stakeholders identified a need for more LGBTQIA+ friendly providers who are knowledgeable about this population's specific health care needs to ensure dignity and respect for all patients. They noted some patients, particularly those who are older, may hesitate to disclose their sexual orientation or gender identify for fear of not receiving adequate or respectful care from their providers.

  "Speaking of language, there has to be a language and culture match. We're seeing that very, not just with our immigrant and refugee community, but also with our LGBTQ+ community, that has to be a culture match. There has to be respect and dignity, I think all of those things are critical to improving access for these underserved folks."—Community Stakeholder

- People with behavioral health challenges: People with a substance use disorder or a severe and persistent mental illness may experience additional challenges to accessing needed care.
- Older adults: Transportation and cost of care can be a barrier for older adults. Additionally, some primary care providers may not accept Medicare patients meaning older adults may need to leave their longtime provider and find a new one that accepts their insurance.
- Latino/a community: There is a lack of bilingual and bicultural providers for the Latino/a community. Health information also needs to be available in Spanish.
- People with low incomes or very low incomes.
- Veterans: There is a large population of veterans in the Rogue Valley that have to find transportation to the VA hospital in Roseburg for care.

As a result of the COVID-19 pandemic, many people have delayed care, either by choice or because of a lack of health care capacity. Older adults in particular may have delayed care due to fear around COVID. Stakeholders spoke to people delaying preventive or routine care, leading to some conditions becoming more severe. With staffing issues in health care many patients are experiencing longer wait time for appointments.

While telehealth has improved access for some, it created additional technology barriers for others. Older adults, people with disabilities, and people living in rural areas without good broadband access may not be able to successfully engage with telehealth. This may be especially true if people do not have a smart phone.

The COVID-19 pandemic highlighted the health disparities in the community and the need for health care and public health to build trust with certain populations that may be understandably hesitant or resistant to getting the COVID-19 vaccine.

Affordable childcare and preschools

Stakeholders prioritized affordable childcare and preschools because it is foundational for family stability and well-being. Reliable and affordable childcare allows caregivers to return to work and attend needed health care services. They described childcare as almost nonexistent in the community, hurting workers in all industries.

Stakeholders spoke to a general lack of availability in current childcare centers, with long waitlists and low admissions rates. There are fewer providers, and they can accept fewer children.

> *"Affordability is one of those factors, but availability is really probably more of an issue right now. Long waitlists, low admission rates."—Community Stakeholder*

Transportation to childcare and preschool can also be a barrier for families. Programs like Head Start do not offer transportation.

The cost of childcare is prohibitive for many families in relation to their income.

A lack of childcare may be especially challenging for parents in recovery. Without reliable childcare, parents may not be able to attend medical detox or a residential treatment program for a SUD because they do not have a safe place for their children.

> *"If someone that needs to go to medical detox, and they have custody of their children and don't have another family member who can watch their children, how do they do that? We know that people will make the choice to not go to detox, even though they may need that, or they may need to go to residential treatment, and if they can't, they can't, even in outpatient. Trying to have someone that they know their children are going to be safe with—Childcare is almost non-existent in this valley."—Community Stakeholder*

Stakeholders shared access to affordable childcare has gotten more challenging in the past couple of years during the pandemic.

> *"Affordable childcare: It is 10 times worse now than it was two years ago, and it was always bad."—Community Stakeholder*

Economic insecurity

Stakeholders identified a lack of living wage jobs as a community challenge, meaning there are jobs, but they may not be paying enough to meet people's needs.

> *"No doubt economic insecurity, lack of a living wage, is a big problem. There's plenty of jobs out there, but are they paying enough for a person to actually take care of their housing needs? Usually not."—Community Stakeholder*

Stakeholders shared the cost of housing is disproportionately high compared to people's income. Families are spending a large portion of their income on housing, citing some may pay 80 or 90% even.

> *"It's said that you shouldn't be paying more than 30% of your income in rent, which I know is largely not true for our population. We're talking 80% to 90% of their income is paid in rent oftentimes."—Community Stakeholder*

Additionally, the cost of health care can be a burden, with a significant medical event leading people to be unable to pay for their housing.

For families that were already behind on payments prior to the pandemic, it only worsened the situation. The COVID-19 pandemic has jeopardized people's housing and ability to pay for services. For families needing to isolate or quarantine, they may have lost wages, further putting stress on their financial situation.

Community Stakeholder Identified Assets

Stakeholders were asked to identify one or two community initiatives or programs that they believe are currently meeting community needs in Jackson or Josephine counties.

Table_Apx 1. Southern Oregon Organizations and Initiatives Addressing Community Needs

Community Need	**Community Organization/Initiative**
Access to Health Care	COVID Collaborative Response: Stakeholders spoke to COVID response in both counties. Specifically, the vaccine initiative in Jackson County has been an example of strong collaboration between organizations to build trust with the community and share information. Additionally, support for people in isolation and quarantine in Jackson County has been a good example of coordination between local CBOs, the Oregon Health Authority, and Public Health to meet community needs.
	La Clínica: A nonprofit organization that provides medical, dental, and behavioral health care to all people, regardless of income. They also provide case managers to support addressing the social determinants of health. Stakeholders emphasized they do a good job of recognizing all the factors that contribute to people's health and well-being, such as housing, childcare, etc. They also meet the needs of many people that may not have insurance.
	Jackson CareConnect and AllCare Coordinated Care Organizations (CCOs): These two CCOs in Southern Oregon provide support for transportation, food security, accommodations when traveling for medical care and more. They also support

	coordination of care and encourage engagement in primary care. Stakeholders emphasized they have been great supporters of the community, ensuring people know what services are available and strengthening engagement with members. They also engage with school districts to meet health care and dental care needs.
Aging Support	Lifelong Housing Certification Project: This project by the Rogue Valley Council of Government is a voluntary certification process for evaluating the accessibility and/or adaptability of homes so that people can age in place.
	Oregon Project Independence: This needs-based, state funded program, is for people with a disability or 60 years or older in Oregon. The supportive services allow people to stay in their home as long as possible.
	Rebuilding Together Rogue Valley: This non-profit organization repairs homes and installs accessibility features, such as grab bars and ramps to prevent falls and support mobility. They also receive some grants to alleviate some of the financial burden on the homeowner.
Behavioral Health	Addictions Recovery Center (ARC): Includes inpatient programs for individuals and families to address substance use challenges. The detox and stabilization services were identified as important for the community.
	ARC certified recovery mentors (CRMs) who engage at the OB clinic with pregnant people using substances: CRMs have lived experience, meaning they can build trust with patients and empathize.
	Birch Grove Health Center: A partnership between Addictions Recovery Center, OnTrack, Jackson County Mental Health, and La Clinica. Stakeholders identified the comprehensive wraparound services, including primary care services linked with behavioral health services, as a strength. *"Those are great examples of how you can link and bring together healthcare, behavioral health, and wraparound services with strong community collaborations and in a loving and respectful way to treat folks."—Community Stakeholder*
	Jackson County Suicide Prevention Coalition: Includes members from various sectors of the community including mental health care, community programs, hospitals, schools, youth programs, primary care clinics, and more to address suicide in Jackson County.
	Jackson County Syringe Exchange Program: This program was identified as showing a lot of flexibility throughout the pandemic and maintaining connections with the community. The program focuses on harm reduction and connects people to many resources.
	Local schools providing mental health services in Jackson and Josephine counties: Stakeholders shared they have seen schools doing a good job of bringing in mental health providers and ensuring the services are accessible for kids and families.

	The Oasis Center: Provides group therapy, crisis intervention, substance use recovery support, and counseling to meet behavioral health needs.
Food Insecurity	Food and Friends: The Meals on Wheels and senior meals program serving Jackson and Josephine counties. The program addresses food insecurity by delivering meals to the homes of older adults and adults with disabilities.
Health and Social Services	Connect Oregon: A coordinated care network of health and social service providers serving Oregon, connected through Unite Us' shared technology platform. The platform allows electronic referrals. Stakeholders shared the technology allows easier tracking of referrals and coordination between organizations.
Housing and Homelessness	Rogue Retreat: Addresses homelessness by providing shelter and housing, as well as supportive services.
Transportation	Rogue Valley Transportation District: Provides accessible transportation services and non-emergent medical transportation.

Community Stakeholders: Opportunities to Work Together

Participants were asked, "What suggestions do you have for organizations to work together to provide better services and improve the overall health of your community?" Stakeholders from Jackson and Josephine counties shared the following opportunities:

Identify opportunities for partnership and shared priorities

Stakeholders emphasized that everyone benefits when organizations work together towards the same goals of serving the community. By looking for opportunities for partnership, this can prevent competition and avoid silos.

> *"Some of the old [leaders] were very siloed and very protective, afraid that if they work together they might lose something, but it seems like when they work together they actually gain something."—Community Stakeholder*

One way to move away from silos and competition is to focus on the needs identified in the CHNA and collaborate on community health improvement plans. The All in for Health work established through the Jefferson Regional Health Alliance during the previous CHNA cycle identifies opportunities for organizations to collaborate on referrals and care coordination.

Specifically related to homelessness, there are opportunities for more collaboration to identify bold and creative solutions. Stakeholders specifically called on health care to be more engaged in this space and part of identifying solutions to better serve people experiencing homelessness. While health care can engage in community-based partnerships related to community needs by providing funding, there is also a lot of value to engaging in community conversations.

> **"I can just honestly say, I think that there is a need for healthcare systems to be present in their communities and visible in their communities beyond the service**

that they deliver. Because they have the ability, and in some ways, people look to them with authority to change how a community looks. They are reflective of the health of a community often."—Community Stakeholder

As folks collaborate in virtual meetings there is opportunity to leverage round tables to find areas of possible overlap and collaboration. Stakeholders noted that representatives at a variety of levels should be engaged in these conversations, particularly the people who have insight into community needs.

While COVID-19 has disrupted some shared work as priorities have shifted, it has also fueled some partnerships and created more necessity for connections between public health agencies, health care, and community-based organizations. Stakeholders shared they hope this communication will continue.

The benefits of partnership are also key considering that many organizations are serving the same clients and engaging with the same groups of people. Working together to create solutions upstream will benefit the patients and organizations by preventing bigger problems in the future.

Systems Change and Centering Equity

Stakeholders discussed the importance of organizations working together to not only address the emergent needs of the community, but also systems that effect health and well-being. They suggested leveraging collective power and voices to advocate for policy changes related to mental health needs.

They also discussed ensuring health equity is a focus of the community work and consider how inequities are affecting populations. Organizations need to look internally at their diversity, equity, and inclusion practices and consider how those values are reflected in their services. Then, the community overall needs to take a wider look at how organizations are collectively centering equity principles.

"There are lots of services, but I think also, more people focused upstream and focusing that passion and energy about thinking, what are the steps we can take to really addressing those social determinants of health needs long term? Not just getting someone into some short-term housing, but how do you actually look at the housing system? Taking more of that systems perspective and channeling that."—Community Stakeholder

Systems change is relevant because it moves beyond responding to immediate need and helps prevent crises or emergencies later.

Improved Connection Between Services and Whole Person Care

Stakeholders emphasized that while there may be a lot of services available, people are not always connected to those services and the care is not always coordinated. They identified a need for more care coordination to connect services and navigate the complexity of health care and health insurance. This is especially important for addressing complex needs.

"We're looking at just one aspect of what's going on, but really having an improved system of care where everything like a whole person is addressed, and having a better way to communicate with each other, I think would be incredibly helpful."—Community Stakeholder

By better coordinating care and making sure clients are connected to the services they need, people will receive more comprehensive support. More coordinated support for patients with a SUD and engaging with health care systems is an example of where organizations can work better together.

Connect Oregon is already working to improve referrals and connections between different agencies. Stronger referral networks will leverage the strengths of the organizations serving the community in Southern Oregon.

LIMITATIONS

While stakeholders and listening sessions participants were intentionally recruited from a variety of types of organizations, there may be some selection bias as to who was selected as a stakeholder. Multiple interviewers conducted the session, which may affect the consistency in how the questions were asked. Multiple note-takers affected the consistency and quality of notes across the different listening sessions.

Some listening sessions were all in person, some were virtual, and some were a combination, which may have affected the quality of the conversation and ability for the facilitator to engage all of the participants.

The analysis was completed by only one analyst and is therefore subject to influence by the analyst's unique identities and experiences.

STAKEHOLDER INTERVIEW QUESTIONS

1. Please state your name, title, and organization as you would like them included in the report.
2. How would you define the community that your organization serves?
3. While a community health needs assessment is primarily used to identify gaps in services and challenges in the community, we want to ensure that we highlight and leverage the community strengths that already exist. Please briefly share the greatest strength you see in the community your organization serves.
4. Please identify and discuss specific unmet health-related needs in your community for the persons you serve. We are interested in hearing about needs related to not only health conditions, but also the social determinants of health.
5. Using the table, please identify the five most important "issues" that need to be addressed to make your community healthy (1 being most important). [See table below.]
6. Has the COVID-19 pandemic influenced or changed the unmet health-related needs in your community? If yes, in what ways?
7. What suggestions do you have for how we can leverage community strengths to address these community needs?
8. Please identify one or two community health initiatives or programs that you see currently meeting the needs of the community.
9. What suggestions do you have for organizations to work together to provide better services and improve the overall health of your community?
10. Is there anything else you would like to share?

Question 5: Using the table below, please identify the five most important "issues" that need to be addressed to make your community healthy (1 being most important). Please note, these needs are listed in alphabetical order.			
	Access to health care services		Food insecurity
	Access to dental care		Gun violence
	Access to safe, reliable, affordable transportation		HIV/AIDS
	Affordable childcare and preschools		Homelessness/lack of safe, affordable housing
	Aging problems		Job skills training
	Bullying in schools		Lack of community involvement and engagement
	Chronic conditions: obesity, heart disease, stroke, and diabetes		Maternal and infant health
	Community violence; lack of feeling of safety		Mental health
	Disability inclusion		Opportunity gap in education (e.g. funding, staffing, support systems, etc. in schools)
	Domestic violence, child abuse/neglect		Racism and discrimination
	Economic insecurity (lack of living wage jobs and unemployment)		Safe and accessible parks/recreation
	Environmental concerns (e.g., climate change, fires/smoke, pollution)		Safe streets for all users (e.g., crosswalks, bike lanes, lighting, speed limits)

	Few community-building events (e.g., arts and cultural events)		Substance use disorder
			Other:

LISTENING SESSION QUESTIONS

- What makes a health community? How can you tell when your community is healthy?
- What's needed? What more could be done to help your community be healthy?
- What's working? What are the resources that currently help your community be healthy?
- Is there anything else related to the topics we discussed today that you think I should know that I haven't asked or that you haven't shared?

COMMUNITY HEALTH SURVEY DATA

The community health survey was open from February 7th to March 20th, distributed in both paper and electronic formats, and available in English and Spanish. The survey captured key information on health and lifestyle factors, community needs, and barriers to accessing health and social services in Jackson and Josephine counties. The data below is for all 1,309 survey responses from both the English and Spanish surveys. This data includes 72 responses that were received from outside the primary service areas. The survey was conducted electively and while efforts were made to engage the diverse populations of our primary service area, survey results are not representative of demographics in the general population. The tables below highlight demographic information for survey respondents.

Question 1. Do you have health coverage or insurance?

	English Survey		Spanish Survey	
	Respondents	Percentage	Respondents	Percentage
Yes	1215	96.4%	39	62.9%
No	42	3.3%	23	37.1%
Skipped Question	4	-	0	-
Total Respondents	1257	-	62	-

Question 2. What kind of health coverage or insurance do you have?

	English Survey		Spanish Survey	
	Respondents	Percentage	Respondents	Percentage
Medicaid	203	16.1%	8	12.9%
Medicare	364	28.9%	11	17.7%
VA, TRICARE or other military health care	35	2.8%	2	3.2%
Indian Health Services (IHS)	9	0.7%	0	0%

I have private coverage through an employer or family member's employer	674	53.5%	7	11.3%
A private plan that I pay for myself	112	8.9%	3	4.8%
I do not have any health insurance now	0	0%	17	27.4%
I do not know	0	0%	1	1.6%
Other	65	5.2%	8	12.9%
Skipped Question	47	-	5	-
Total Respondents	1214	-	57	-

Question 3. If you do not have health coverage or insurance, what are the main reasons why?

	English Survey		**Spanish Survey**	
	Respondents	Percentage	Respondents	Percentage
It costs too much	94	7.5%	15	24.2%
I do not think I need insurance	26	2.1%	0	0%
I am waiting to get coverage through a job	51	4.0%	2	3.2%
Signing up for insurance is too confusing	28	2.2%	0	0%
I have not had time to do it	9	0.7%	3	4.8%
Other	52	4.1%	4	6.5%
Skipped Question	1052	-	39	-
Total Respondents	209	-	23	-

Question 4. Have you or anyone in your household needed health care in the last year?

	English Survey		**Spanish Survey**	
	Respondents	Percentage	Respondents	Percentage
Yes	1112	88.2%	41	66.1%
No	139	11.0%	20	32.3%
Skipped Question	10	-	1	-
Total Respondents	1251	-	61	-

Question 5. Did you get all the health care you needed? Check all that apply.

	English Survey		**Spanish Survey**	
	Respondents	Percentage	Respondents	Percentage
We got all the care we needed	667	52.9%	21	33.9%
We got some but not all the care we needed	334	26.5%	13	21.0%

We had to delay getting care we needed	178	14.1%	8	12.9%
We got no care at all	13	1.0%	1	1.6%
I do not know	6	0.5%	1	1.6%
Skipped Question	152	-	18	-
Total Respondents	1109	-	44	-

Question 6. For the most recent time you or anyone in your household put off or went without health care, what were the reasons?

	English Survey		Spanish Survey	
	Respondents	Percentage	Respondents	Percentage
Cost	381	30.2%	20	32.3%
Not having a primary health care provider	171	13.56%	4	6.5%
Not knowing where to go	100	7.9%	4	6.5%
Could not get an appointment soon enough	341	27.0%	4	6.5%
Clinic is not open when I can go	81	6.4%	1	1.6%
Needed childcare	64	5.1%	0	0
Needed transportation	34	2.7%	2	3.2%
Not having a health care provider that understands my culture or speaks my language	20	1.6%	4	6.5%
COVID-19: appointment cancellation, concern of infection, or other related concern	236	18.7%	6	9.7%
Not applicable	303	24.0%	13	21.0%
Other reasons	101	8.0%	3	4.8%
Skipped Question	104	-	12	-
Total Respondents	1157	-	50	-

Question 7. A primary health care provider is the person you see if you need a health check-up, want advice about a health problem, or get sick or hurt. Do you have a primary care provider?

	English Survey		Spanish Survey	
	Respondents	Percentage	Respondents	Percentage
Yes	1101	87.3%	39	62.9%
No	152	12.1%	22	35.5%
Skipped Question	8	-	1	-
Total Respondents	1253	-	61	-

Question 8. Have you ever been told by any health care professional that you have any of the following?

	English Survey		Spanish Survey	
	Respondents	Percentage	Respondents	Percentage
Diabetes or high blood sugar	210	16.7%	13	21.0%
Asthma	217	17.2%	7	11.3%
High blood pressure	401	31.8%	7	11.3%
High cholesterol	309	24.5%	7	11.3%
Heart disease	73	5.8%	2	3.2%
Cancer	114	9.0%	1	1.6%
Depression	358	28.4%	16	25.8%
Post-traumatic stress disorder (PTSD)	149	11.8%	1	1.6%
Anxiety	400	31.7%	12	19.4%
Substance use disorder	47	3.7%	1	1.6%
Another ongoing health condition	336	26.7%	5	8.1%
Skipped Question	258	-	27	-
Total Respondents	1003	-	35	-

Question 9. In the last year, did you receive care using any of the following?

	English Survey		Spanish Survey	
	Respondents	Percentage	Respondents	Percentage
Urgent care	395	31.3%	9	14.5%
Emergency room	331	26.3%	8	12.9%
Telemedicine (video visit)	569	45.1%	16	25.8%
Skipped Question	368		35	-
Total Respondents	893		27	-

Question 10. In the last year, did you need counseling or mental health treatment?

	English Survey		Spanish Survey	
	Respondents	Percentage	Respondents	Percentage
Yes	430	34.1%	15	24.2%
No	814	64.6%	43	69.4%
Skipped Question	17		4	-
Total Respondents	1244		58	-

Question 11. Did you get all the counseling or mental health care you needed?

	English Survey		Spanish Survey	
	Respondents	Percentage	Respondents	Percentage
Yes	261	20.7%	15	24.2%
No	166	13.16%	7	11.3%

Skipped Question	834	-	40	-
Total Respondents	166	-	22	-

Question 11a. Please check all the types of counseling or mental health care you did not receive. Check all that apply.

	English Survey		Spanish Survey	
	Respondents	Percentage	Respondents	Percentage
Support for a personal problem	96	7.6%	4	6.5%
Treatment for a mental health condition like PTSD, depression or anxiety	114	9.0%	1	1.6%
Counseling to quit tobacco, alcohol, or drug use	12	1.0%	0	0%
Other kinds of care	24	1.9%	2	3.2%
Skipped Question	1099	-	6	-
Total Respondents	162	-	56	-

Question 12. In the last year, have you or anyone in your household had concerns about alcohol, tobacco, or substance use?

	English Survey		Spanish Survey	
	Respondents	Percentage	Respondents	Percentage
Yes	171	13.6%	6	9.7%
No	1077	85.4%	48	77.4%
Skipped Question	13	-	8	-
Total Respondents	1248	-	54	-

Question 13. Were you able to get the help you needed with alcohol, tobacco, or substance use?

Smoking Cessation	English Survey		Spanish Survey	
	Respondents	Percentage	Respondents	Percentage
Yes	75	6.0%	2	3.2%
No	32	2.5%	2	3.2%
Not applicable	54	4.3%	1	1.6%
Skipped Question	1100	-	57	-
Total Respondents	161	-	5	-

Alcohol Treatment Program	English Survey		Spanish Survey	
	Respondents	Percentage	Respondents	Percentage
Yes	50	4.0%	2	3.2%
No	52	4.1%	3	4.8%
Not applicable	46	3.7%	1	1.6%

Skipped Question	1113	-	56	-
Total Respondents	148	-	6	-

Medication-Assisted Treatment Program	English Survey		Spanish Survey	
	Respondents	Percentage	Respondents	Percentage
Yes	51	4.0%	1	1.6%
No	34	2.7%	2	3.2%
Not applicable	65	5.2%	2	3.2%
Skipped Question	1100	-	57	-
Total Respondents	161	-	5	-

Substance Use Disorder Counseling and Treatment	English Survey		Spanish Survey	
	Respondents	Percentage	Respondents	Percentage
Yes	65	5.2%	2	3.2%
No	32	2.5%	1	1.6%
Not applicable	56	4.4%	2	3.2%
Skipped Question	1100	-	57	-
Total Respondents	161	-	5	-

Question 14. How would you rate your overall physical health?

	English Survey		Spanish Survey	
	Respondents	Percentage	Respondents	Percentage
Excellent	59	4.7%	2	3.2%
Very good	340	27.0%	14	22.6%
Good	585	46.4%	17	27.4%
Fair	227	18%	27	43.6%
Poor	44	3.5%	1	1.6%
Skipped Question	6	-	1	-
Total Respondents	1255	-	61	-

Question 15. How would you rate your overall mental health?

	English Survey		Spanish Survey	
	Respondents	Percentage	Respondents	Percentage
Excellent	137	10.9%	4	6.5%
Very good	329	26.1%	10	16.1%
Good	482	38.2%	22	35.5%
Fair	267	21.2%	22	35.5%

Poor	43	3.4%	3	4.8%
Skipped Question	3	-	1	-
Total Respondents	1258	-	61	-

Question 16. In the last year, how often did you feel socially isolated or experience loneliness?

	English Survey		Spanish Survey	
	Respondents	Percentage	Respondents	Percentage
None of the time	307	24.4%	19	30.7%
Some of the time	674	53.5%	30	48.4%
Most of the time	224	17.8%	11	17.7%
All of the time	50	4.0%	2	3.2%
Skipped Question	6	-	0	-
Total Respondents	1255	-	62	-

Question 17. How often do you have someone available to do each of the following?

	English Survey		Spanish Survey	
Love you and make you feel wanted	Respondents	Percentage	Respondents	Percentage
None of the time	60	4.8%	5	8.1%
Some of the time	284	22.5%	12	19.4%
Most of the time	336	26.7%	18	29.0%
All of the time	570	45.2%	26	41.9%
Skipped Question	11	-	1	-
Total Respondents	1250	-	61	-

	English Survey		Spanish Survey	
Give you good advice about a crisis	Respondents	Percentage	Respondents	Percentage
None of the time	75	6.0%	8	12.9%
Some of the time	283	22.4%	15	24.2%
Most of the time	439	34.8%	21	33.9%
All of the time	451	35.8%	16	25.8%
Skipped Question	13	-	2	-
Total Respondents	1248	-	60	-

	English Survey		Spanish Survey	
Get together for relaxation	Respondents	Percentage	Respondents	Percentage
None of the time	121	9.6%	6	9.7%
Some of the time	445	35.3%	28	45.2%
Most of the time	321	25.5%	12	19.4%

All of the time	361	28.6%	14	22.6%
Skipped Question	13	-	2	-
Total Respondents	1248	-	60	-

	English Survey		Spanish Survey	
Confide in or talk to about your problems	Respondents	Percentage	Respondents	Percentage
None of the time	96	7.6%	8	12.9%
Some of the time	345	27.4%	16	25.8%
Most of the time	361	28.6%	18	29.0%
All of the time	449	35.6%	19	30.7%
Skipped Question	10	-	1	-
Total Respondents	1251	-	61	-

	English Survey		Spanish Survey	
Help you if you were confined to a bed	Respondents	Percentage	Respondents	Percentage
None of the time	170	13.5%	8	12.9%
Some of the time	240	19.0%	13	21.0%
Most of the time	325	25.8%	22	25.5%
All of the time	477	37.8%	18	29.0%
Skipped Question	49	-	1	-
Total Respondents	1212	-	61	-

Question 18. In the last year, did you participate in a religious community?

	English Survey		Spanish Survey	
	Respondents	Percentage	Respondents	Percentage
Christianity	572	45.4%	26	41.9%
Islam	22	1.7%	0	0%
Buddhism	41	3.3%	0	0%
Judaism	15	1.2%	0	0%
No, I am atheist or agnostic	445	35.3%	7	11.3%
Other	0	0%	22	35.5%
Skipped Question	186	-	7	-
Total Respondents	1075	-	55	-

Question 19. During the last two weeks, how often have you been bothered by the following?

	English Survey		Spanish Survey	
Little interest or pleasure in doing things	Respondents	Percentage	Respondents	Percentage

Not at all	628	49.8%	35	56.5%
Several days	428	33.9%	19	30.7%
Over half the days	120	9.5%	2	3.2%
Nearly every day	73	5.8%	3	4.8%
Skipped Question	12	-	3	-
Total Respondents	1249	-	59	-

	English Survey		**Spanish Survey**	
Feeling down, depressed or hopeless	Respondents	Percentage	Respondents	Percentage
Not at all	626	49.6%	36	58.1%
Several days	408	32.4%	18	29.0%
Over half the days	157	12.5%	2	3.2%
Nearly every day	58	4.6%	2	3.2%
Skipped Question	12	-	4	-
Total Respondents	1249	-	58	-

	English Survey		**Spanish Survey**	
Feeling nervous, anxious, or on edge	Respondents	Percentage	Respondents	Percentage
Not at all	444	35.2%	36	58.1%
Several days	537	42.6%	17	27.4%
Over half the days	159	12.6%	3	4.8%
Nearly every day	110	8.7%	1	1.6%
Skipped Question	11	-	5	-
Total Respondents	1250	-	57	-

	English Survey		**Spanish Survey**	
Not being able to stop or control worrying	Respondents	Percentage	Respondents	Percentage
Not at all	579	45.9%	35	56.5%
Several days	411	32.6%	20	32.3%
Over half the days	148	11.7%	1	1.6%
Nearly every day	107	8.5%	3	4.8%
Skipped Question	16	-	3	-
Total Respondents	1245	-	59	-

Question 20. How often have you had these hard times or traumatic events in your life?

	English Survey

	Not at all		Some		A lot	
Life changing illness or injury	459	36.4%	636	50.4%	158	12.5%
Neglect of any kind	785	62.3%	355	28.2%	105	8.3%
Lived with someone with mental illness	602	47.7%	411	32.6%	230	18.2%
Lived with someone with substance abuse issues	676	53.6%	385	30.5%	186	14.8%
Witnessed or experienced violence	696	55.2%	417	33.1%	133	10.6%
Made to do something sexual that you did not want to do	916	72.6%	256	20.3%	68	5.4%
Physically hurt or threatened by an intimate partner or parent/caregiver	891	70.7%	268	21.3%	86	6.8%
Abuse of any kind	717	56.9%	412	32.7%	111	8.8%
Parents were separated or divorced during your childhood (ages 0 to 18)	730	57.9%	224	17.8%	285	22.6%
A personal suicide attempt	1048	83.1%	135	10.7%	53	4.2%
A suicide or suicide attempt by a close friend or family member	786	62.3%	367	29.1%	85	6.7%
Unexpected death of a loved one	469	37.2%	573	45.4%	200	15.9%
Another traumatic event	527	41.8%	521	41.3%	170	13.5%
Skipped Question	-		-		-	
Total Respondents	-		-		-	

	Spanish Survey					
	Not at all		Some		A lot	
Life changing illness or injury	39	62.9%	14	22.6%	8	12.9%
Neglect of any kind	45	72.6%	10	16.1%	5	8.1%
Lived with someone with mental illness	47	75.8%	6	9.7%	6	9.7%
Lived with someone with substance abuse issues	48	77.4%	9	14.5%	3	4.8%
Witnessed or experienced violence	42	67.7%	9	14.5%	8	12.9%
Made to do something sexual that you did not want to do	48	77.4%	6	9.7%	4	6.5%
Physically hurt or threatened by an intimate partner or parent/caregiver	46	74.2%	5	8.1%	7	11.3%
Abuse of any kind	39	62.9%	9	14.5%	10	16.1%
Parents were separated or divorced during your childhood (ages 0 to 18)	45	72.6%	6	9.7%	9	14.5%
A personal suicide attempt	-	-	-	-	-	-
A suicide or suicide attempt by a close friend or family member	46	74.2%	8	12.9%	6	9.7%
Unexpected death of a loved one	21	33.9%	24	38.7%	14	22.6%
Another traumatic event	25	40.3%	25	40.3%	7	11.3%

Skipped Question			
Total Respondents			

Question 21. Do you have any children (under 18 years of age)?

	English Survey		Spanish Survey	
	Respondents	Percentage	Respondents	Percentage
Yes	480	38.1%	37	59.7%
No	772	61.2%	22	35.5%
Skipped Question	9	-	3	-
Total Respondents	1252	-	59	-

Question 22. Have you ever been told by a health care professional that any of your children have any of the following?

	English Survey		Spanish Survey	
	Respondents	Percentage	Respondents	Percentage
Diabetes or high blood sugar	23	1.8%	2	3.2%
Asthma	73	5.8%	4	6.5%
A behavioral or mental health diagnosis (such as depression, anxiety, or ADHD)	148	11.7%	6	9.7%
A developmental delay or learning disability (such as autism or dyslexia)	74	5.9%	4	6.5%
Post-traumatic stress disorder (PTSD)	34	2.7%	2	3.2%
Another ongoing health condition	64	5.1%	1	1.6%
Skipped Question	999	-	51	-
Total Respondents	262	-	11	-

Question 23. The following questions are about where you live. Please choose the number that best represents your opinion of each statement. If you do not know, please respond "DK."

	English Survey											
	Strongly Disagree		Disagree		Neutral		Agree		Strongly agree		Don't know	
My community has health care options available.	43	3.4%	132	10.5%	180	14.3%	520	41.2%	345	27.4%	28	2.2%
My community is a good place	46	3.7%	152	12.1%	295	23.4%	472	37.4%	226	17.9%	58	4.6%

to raise children.												
My community is a good place to grow old.	46	3.7%	168	13.3%	284	22.5%	473	37.5%	251	19.9%	28	2.2%
I feel safe in my home.	21	1.7%	47	3.7%	133	10.6%	468	37.1%	573	45.4%	10	0.8%
My community feels safe.	45	3.6%	175	13.9%	284	22.5%	516	40.9%	222	17.6%	8	0.6%
I feel prepared for an emergency.	31	2.5%	134	10.6%	298	23.6%	558	44.3%	219	17.4%	7	0.6%
People of all races, ethnicities, backgrounds, and beliefs in my community are treated fairly	130	10.3%	320	25.4%	305	24.2%	320	25.4%	108	8.6%	62	4.9%
People in my community can access mental health services and substance use disorder treatment.	197	15.6%	301	23.9%	261	20.7%	274	21.7%	113	9.0%	107	8.5%
Healthy food is available in my community.	23	1.8%	74	5.9%	158	12.5%	655	51.9%	332	26.3%	10	0.8%
There are places to be physically active near my home.	12	1.0%	58	4.6%	105	8.3%	580	46.0%	483	38.3%	12	1.0%
I have enough financial resources to meet my basic needs.	66	5.2%	146	11.6%	191	15.2%	479	38.0%	353	28.0%	6	0.5%

Skipped Question	-	-	-	-	-	-
Total Respondents	-	-	-	-	-	-

	Spanish Survey											
	Strongly Disagree		Disagree		Neutral		Agree		Strongly agree		Don't know	
My community has health care options available.	1	1.6%	3	4.8%	12	19.4%	26	41.9%	10	16.1%	8	12.9%
My community is a good place to raise children.	2	3.2%	3	4.8%	10	16.1%	31	50%	13	21.0%	1	1.6%
My community is a good place to grow old.	1	1.6%	4	6.5%	18	29.0%	23	37.1%	11	17.7%	3	4.8%
I feel safe in my home.	1	1.6%	4	6.5%	12	19.4%	23	37.1%	17	27.4%	3	4.8%
My community feels safe.	0	0%	4	6.5%	18	29.0%	26	41.9%	12	19.4%	0	0%
I feel prepared for an emergency.	4	6.45%	5	8.1%	20	32.3%	20	32.3%	6	9.7%	5	8.1%
People of all races, ethnicities, backgrounds, and beliefs in my community are treated fairly	4	6.5%	6	9.7%	22	35.5%	15	24.2%	4	6.5%	9	14.5%
People in my community can access mental health services and substance use	3	4.8%	2	3.2%	21	33.9%	14	22.6%	6	9.7%	14	22.6%

disorder treatment.												
Healthy food is available in my community.	1	1.6%	4	6.5%	12	19.4%	26	41.9%	12	19.4%	3	4.8%
There are places to be physically active near my home.	1	1.6%	5	8.1%	10	16.1%	27	43.6%	15	24.2%	2	3.2%
I have enough financial resources to meet my basic needs.	3	4.8%	4	6.5%	20	32.3%	23	37.1%	4	6.5%	5	8.1%
Skipped Question	-		-		-		-		-		-	
Total Respondents	-		-		-		-		-		-	

Question 24. What zip code do you live in?

	English Survey		Spanish Survey	
County	Respondents	Percentage	Respondents	Percentage
Jackson	819	70.6%	55	96.5%
Josephine	333	28.7%	2	3.5%
Coos, Douglas, Klamath, Lane, Marion, Wasco	8	0.7%	0	0%
Skipped Question	29	-	5	-
Total Respondents	1160	-	57	-

Question 25. In what year were you born?

Age Range	English Survey		Spanish Survey	
	Count	Percentage	Count	Percentage
Under 18	-	-	1	2.3%
18-34	200	17.3%	16	36.4%
35-54	462	39.9%	19	43.2%
55-64	218	18.8%	6	13.6%
65+	279	24.1%	2	4.5%
Skipped Question	30	-	18	-
Total Respondents	1159	100%	44	-

Question 26. Are you Hispanic or Latino/Latina/Latinx?

Latin/Hispanic/Spanish Origin	English Survey		Spanish Survey	
	Count	Percentage	Count	Percentage
No	1049	91.46%	3	4.8%
Yes	98	8.54%	56	90.3%
Skipped	42	-	2	-
Total Responses	1147	-	46	-

Question 27. What is your race?

Race	English Survey		Spanish Survey	
	Count	Percentage	Count	Percentage
American Indian or Alaska Native	10	0.8%	6	9.7%
Asian	24	2.0%	2	3.2%
Black or African American	24	2.0%	-	-
Black or African American/Asian	1	0.1%	-	-
Do not know, not sure	6	0.5%	5	8.1%
Middle Eastern/North African	1	0.1%	-	-
Native Hawaiian or other Pacific Islander	5	0.4%	5	8.1%
Prefer not to answer	57	4.8%	8	12.9%
White	1008	85.4%	30	48.4%
White/American Indian or Alaska Native	22	1.9%	-	-
White/American Indian or Alaska Native/Do not know, not sure	1	0.1%	-	-
White/Asian	7	0.6%	0	0%
White/Asian/American Indian or Alaska Native	1	0.1%	-	-
White/Black or African American	2	0.2%	-	-
White/Black or African American/American Indian or Alaska Native	3	0.3%	-	-
White/Black or African American/Native Hawaiian or Other Pacific Islander	1	0.1%	-	-
White/Do not know, not sure	2	0.2%	-	-
White/Middle Eastern/North African	1	0.1%	-	-
White/Native Hawaiian or Other Pacific Islander	2	0.2%	-	-
White/Prefer Not to Answer	3	0.3%	-	-
Skipped Question	7	-	7	-
Total Responses	1181	100%	55	-

Question 28. What is your gender?

Gender Identity	English Survey		Spanish Survey	
	Count	Percentage	Count	Percentage
Female	970	82.3%	50	80.7%
Male	182	15.4%	5	8.1%

Transgender	8	0.7%	-	0%
Gender non-binary	-	-	1	1.6%
Gender non-conforming	3	0.3%	-	0%
Choose not to answer	14	1.2%	1	1.6%
Other	2	0.2%	1	1.6%
Skipped Question	10	-	4	-
Total Responses	1179	100%	58	-

Question 29. What is your sexual orientation?

Sexual Orientation	English Survey		Spanish Survey	
	Count	Percentage	Count	Percentage
Asexual	53	4.5%	6	9.7%
Bisexual	64	5.5%	2	3.2%
Gay	11	0.9%	-	-
Heterosexual or straight	919	78.4%	34	54.8%
Lesbian	15	1.3%	-	-
Pansexual	6	0.5%	-	-
Queer	6	0.5%	-	-
Choose not to answer	92	7.8%	10	16.1%
Other	6	0.5%	1	1.6%
Skipped Question	17	-	9	-
Total Responses	1172	100%	53	-

Question 30. How many people currently live in your home? Count adults, seniors, and children under 18? Number of adults (18 to 65 years), number of seniors (over age 65), and number of children (birth to 18).

	English Survey	Spanish Survey
Number of adults age 18-65 in the house	Number of respondents	Number of respondents
0	62	1
1	250	5
2	585	19
3	143	8
4	43	4
5	20	5
6	12	0
7	1	0
8	2	0
18	3	0
19	2	0
32	1	0

80	1	0
Total Responses	1125	42

	English Survey	Spanish Survey
Number of seniors over age 65 in the house	**Number of respondents**	**Number of respondents**
0	535	16
1	242	4
2	175	3
3	4	1
4	2	0
10	3	0
800	1	0
Total Responses	962	24

	English Survey	Spanish Survey
Number of children ages birth to 18 in the house	**Number of respondents**	**Number of respondents**
0	507	9
1	215	5
2	180	12
3	60	3
4	13	4
5	2	0
6	2	0
7	2	0
24	1	0
Total Responses	982	33

Question 31. What is your gross household income (the amount before taxes and deductions are taken out) for last year (2021)?

Household Income	English Survey		Spanish Survey	
	Count	Percentage	Count	Percentage
Less than $20,000	162	14.3%	14	22.6%

$20,001 to $40,000	184	16.3%	31	50.0%
$40,001 to $60,000	204	18.1%	7	11.3%
$60,001 to $80,000	159	14.1%	1	1.6%
$80,001 to $100,000	168	14.9%	1	1.6%
$100,000 and over	252	22.3%	2	3.2%
Skipped Question	60	-	6	
Total Responses	1129	-	56	

Question 32. What is your current employment status?

Employment Status	**English Survey**		**Spanish Survey**	
	Count	Percentage	Count	Percentage
Employed full time (40 hours per week)	635	50.4%	25	40.3%
Employed part time	131	10.4%	12	19.4%
Seasonal, service industry, gig economy	6	0.5%	2	3.2%
Self-employed	47	3.7%	4	6.5%
Retired	236	18.7%	1	1.6%
Unable to work due to illness, injury, or disability	91	7.2%	3	4.8%
Homemaker or stay at home parent	33	2.6%	7	11.3%
Student	15	1.2%	0	0%
Unemployed	55	4.4%	5	8.1%
Skipped Question	12	-	3	-
Total Responses	1249	-	59	-

Question 33. Do you work more than one job?

	English Survey		**Spanish Survey**	
	Count	Percentage	Count	Percentage
Yes	196	15.5%	5	8.1
No	1027	81.4%	53	85.5%
Skipped Question	38	-	4	-
Total Responses	1223	-	58	-

Question 34. Do you have to work more than one job to afford living expenses?

	English Survey		**Spanish Survey**	
	Count	Percentage	Count	Percentage
Yes	149	11.8%	14	22.6%
No	46	3.7%	31	50.0%
Skipped Question	1066	-	17	-
Total Responses	195	-	45	-

Question 35. Have you or someone in your household lost a job or hours due to COVID-19?

	English Survey		**Spanish Survey**	
	Count	Percentage	Count	Percentage

Yes	386	30.6%	27	43.6%
No	855	67.8%	31	50.0%
Skipped Question	20	-	4	-
Total Responses	1241	-	58	-

Question 36. Which of the following best describes your housing situation today?

	English Survey		**Spanish Survey**	
	Count	Percentage	Count	Percentage
I have housing and I am not worried about losing it	931	78.4%	39	62.9%
I have housing, but I am worried about losing it	172	14.5%	12	19.4%
I do not have housing, and I'm staying with friends or family	28	2.4%	2	3.2%
I'm staying in a shelter	22	1.9%	1	1.6%
I'm staying in my car or on the street	11	0.9%	0	0%
Other	24	2.0%	4	6.5%
Skipped Question	-	-	-	-
Total Responses	1188	-	58	-

Question 37. Have you or someone in your household lost your housing due to COVID-19 or wildfires?

	English Survey		**Spanish Survey**	
	Count	Percentage	Count	Percentage
Not applicable	1093	86.7%	46	74.2%
Wildfires	73	5.8%	9	14.5%
COVID-19	66	5.2%	2	3.2%
Skipped Question	29	-	5	-
Total Responses	1232	-	57	-

38. In the last year, have you or someone in your household had to go without any of the following when it was really needed because you were having trouble making ends meet?

	English Survey					
	No		Yes		Not Applicable	
Food	1032	81.8%	137	10.9%	54	4.3%
Utilities (water, electricity, heat)	1058	83.9%	105	8.3%	61	4.8%
Transportation	1003	79.5%	159	12.6%	62	4.9%
Clothing	1020	80.9%	150	11.9%	55	4.4%
Personal hygiene items	1039	82.4%	123	9.8%	53	4.2%
Stable housing or shelter	1036	82.2%	122	9.7%	62	4.9%
Medical care	945	74.9%	211	16.7%	61	4.8%
Medicine	1001	79.4%	163	12.9%	56	4.4%
Childcare	783	62.1%	91	7.2%	324	25.7%
Dental care	909	72.1%	254	20.1%	60	4.8%
Skipped Question	-		-		-	

Total Respondents	-		-		-	

	Spanish Survey					
	No		Yes		Not Applicable	
Food	33	53.2%	14	22.6%	9	14.5%
Utilities (water, electricity, heat)	37	59.7%	10	16.1%	7	11.3%
Transportation	37	59.7%	8	12.9%	9	14.5%
Clothing	36	58.1%	10	16.1%	9	14.5%
Personal hygiene items	39	62.9%	6	9.7%	9	14.5%
Stable housing or shelter	38	61.3%	5	8.1%	11	17.7%
Medical care	35	56.5%	10	16.1%	9	14.5%
Medicine	39	62.9%	6	9.7%	9	14.5%
Childcare	33	53.2%	8	12.9%	13	21.0%
Dental care	31	50.0%	17	27.4%	7	11.3%
Skipped Question	-		-		-	
Total Respondents	-		-		-	

Question 39. What health services are needed but are not available near where you live?

English Survey					
Total responses received	652	Responses with no concern listed		51	
RESPONSES FEATURING IDENTIFIED SERVICES					
Mental health	221	Urgent care	31	Pain care	4
Specialty care	106	Alternative care	13	Misc. medical	4
Primary care	62	Pharmacy	8	Testing / Labs	3
Children/Teens	60	Women's Health	7	Vaccination	2
Substance use	47	Vision	6	Dialysis	2
Pediatrics	37	Therapy	4	Hearing	2
Dental	35	Vision	6	Health education	1

RESPONSES REGARDING BARRIERS TO CARE		RESPONSES NOTING AREAS OF SPECIAL CONCERN	
General access	36	**Elders/Aging**	24
Wait times	32	**Homeless**	12
Insurance	27	**COVID**	11
Affordability	24	**Crime & Safety**	6
Quality of care	16	**Nutrition**	6
Location	10	**Childcare**	5
Transportation	8	**Health & Fitness**	5
Choice	6	**Hospital**	5
Multi-cultural inclusion	4	**Community**	4
LGBTQIA+	3	**Veterans**	2
Disability	3		

COMMUNITY-IDENTIFIED AREAS OF SPECIALTY CLINICAL NEEDS Includes both English and Spanish survey responses		
Specialties		
Allergists	Hematology/oncology	Pediatric intensive care
Bariatrics	Internists	Pediatric neurology
Cardiac surgery	Neurology	Pediatric orthopedics
Dermatology	Nephrology	Pediatric surgery
Diabetic care	Neurosurgery	Podiatry
Endocrinology	Otolaryngology (ear, nose and throat)	Pulmonology
Gastroenterology	Pediatrics (general and specialty)	Rheumatology

<table>
<tr><td>Genetics</td><td>Pediatric cardiology</td><td>Trauma</td></tr>
<tr><td>Gerontology</td><td>Pediatric developmental specialist</td><td>Urology</td></tr>
<tr><td>Hepatology</td><td>Pediatric endocrinology</td><td>Vascular medicine</td></tr>
<tr><th>Areas of specialized knowledge</th><th colspan="2">Requested therapies</th></tr>
<tr><td>Brain Health</td><td colspan="2">Aquatic therapy</td></tr>
<tr><td>Connective tissue disorder disorders</td><td colspan="2">Food occupational therapy</td></tr>
<tr><td>Celiac disease</td><td colspan="2">Lymphedema therapy</td></tr>
<tr><td>GVHD (graft versus host disease)</td><td colspan="2">Occupational therapy</td></tr>
<tr><td>Ehlers Danlos Syndrome</td><td colspan="2">Physical therapy</td></tr>
<tr><td>Rare disease</td><td colspan="2">Speech therapy</td></tr>
<tr><td>Long Covid</td><td colspan="2"></td></tr>
<tr><td>Spine and back</td><td colspan="2"></td></tr>
</table>

SELECT ILLUSTRATIVE COMMENTS

“Mental health and substance abuse programs…there is far greater need than resources available. It can be months before you can get an appointment outside of a crisis situation. There’s not enough prevention so things get to a breaking point so often before help can be received.”

“This area does not have a lot of mental health services. Especially when it comes to insurance. Most require certain types of insurance and if they do take your insurance they’re booking months out. For people who need services asap it makes it extremely difficult.”

“Need more mental Healthcare. Wait lists are long, providers aren't accepting new patients, patient systems are not user friendly if a cancelation or reschedule needs to occur, patients get dismissed from hard fought for mental Healthcare all the time regardless of how needed the care is.”

“Need more providers (PCPs, cardiologists, connective tissue specialists, PT’s, OT’s, DO’s, LMT’s, Nucca chiropractors) in the area who have expertise with Ehlers Danlos syndrome and related “comorbid” conditions. Also need more mental health counselors for adolescents, and ADHD therapists.”

“Podiatry, Diabetic care specifically, Ear, Nose, and Throat care, not enough mental health care counseling to have a choice of who you can go to. Pediatric Doctors, elderly health care doctors, neurologists. We need more naturopathic doctors. I am sure I am missing a lot more specialists that we need here in the valley.”

“Our community needs more Docs in Geriatrics. Several Gerontologists would be helpful plus other services like mental health for elders, yoga for elders, massage therapists for elders! We are an aging society here in the Rogue Valley.”

"Need a Wellness Clinic, need Acupuncture, need DO who practice manipulation!! Need more PCP to choose from who are willing to take time to listen and partner with me to care for my health needs. Need dietician at the Wellness center to support me in healthy eating and lifestyle."

"Not enough primary health providers. Takes too long to get appointments. Also, when given referral it takes to long for someone to get back to you. Not enough specialty doctors."

"Primary care- it's unreasonable and unacceptable that providers are so busy that it can take several months to get an appointment."

"Pediatric specialist. More lab services- most close by 2:30pm (before school is even out for the day) and the ones that are open later often misplace or do not run labs in the appropriate time frame, meaning labs/test have to be redone multiple times. Additional primary care providers are needed. There is a 6-12 month wait to get a new physician."

"More services and specialties for children, including physical and occupational therapy, pediatric specialties, especially surgeons. More mental health providers or counselors that accept new patients. Eating disorder center and treatment facility. Drug rehabilitation centers."

"More mental health/substance use treatment. Too long of a wait due to lack of locations / staffing / resources."

"More affordable substance abuse programs for those who need them. This area does not have enough population to support a major teaching hospital like Oregon Health Sciences University, so we are missing that."

"I'm not sure what is available in regards to treatment, mental health and health care for people who can't afford it in our community. Would like to think there was access to those in need without too many "hoops"."

"I think everything is available if you have insurance and you're patient to get an appointment. I think the situation with Covid has made it very difficult to get basic services or prompt appointments if you have an emergency."

"Many services are available, they are just extremely expensive and sometime I don't use them because of the price even though I have insurance."

"We have an increasing growing of senior community. We need geriatric doctors, physician assistants, facilities that are geared to the senior community."

"Need more services for elderly and doctors that are bilingual and bicultural. We need classes that are free to control certain chronic diseases. Endocrinologist, rheumatoid, the selection here is bad."

"Community-centered, community sensitive, stable primary care. There is a revolving door for providers at our clinic, and hostile front desk staff have been tolerated for DECADES. There is no pediatrician, and no family practice doc taking new patients."

"Ongoing mental health is in a shortage, and many insurance companies refuse to cover additional therapeutic services outside of individual therapy. Covid has shut down many needed services which is unacceptable for overall health and well-being."

"Getting medicine is also a challenge. Pharmacies are understaffed and don't communicate well with customers. It can take over a week to get an RX filled. We have had to switch pharmacies in the last 90 days due to poor management of medications."

"As a mom of three little kids, it's very hard to get to my doctor's appointments when they specifically say I can't bring anyone with me. Who is going to watch my three kids? My husband has to work. Or doctor's appointments where they say that my kids' siblings can't come to their appointment. I don't have a place to take them if I don't bring them to doctor's appointments for their siblings."

"Almost no women of color provide services for those of us who would prefer to be served by someone with our experience."

"There are many medical providers within my community however, there aren't many (or any) Bilingual bicultural providers."

"We need geriatric and LGBTQ+ health & culturally competent trained physical and behavioral health professionals."

"Free dental and hearing aid services for people that are low income. Medicare doesn't cover these services so I can't get them."

Spanish Survey					
Total responses received		20	**Responses with no concern listed**		6
RESPONSES FEATURING IDENTIFIED SERVICES					
Mental health	4	**Urgent care**	2	**Physical Therapy**	1
Specialty care	3	**Hospital**	1	**Misc. medical**	
RESPONSES REGARDING BARRIERS TO CARE			**RESPONSES NOTING AREAS OF SPECIAL CONCERN**		
Insurance		2	**Uninsured**		2
Children and teens		2	**Homeless**		1
Bilingual care		1			

SELECT ILLUSTRATIVE COMMENTS

"Physical therapy for the uninsured"

"Mental Health Crisis"

"More services to help people living on the streets."

"For people without insurance, it is difficult to find colonoscopy services."

"Staff for youth with anxiety and depression."

"Child psychiatrists, good mental health therapists who speak good Spanish, truly bilingual occupational and speech therapists, help in Spanish for all kinds of services that many people don't know or understand."

"Mental health and dental services."

Question 40. What one thing could be done to improve the health and quality of life for your family?

English Survey			
Total responses received	709	**Responses with no concern listed**	34
AREAS OF CONCERN FOR SELF AND FAMILY			
Economic concerns	149	**Dental**	21
Access to health care	94	**Air quality, smoke and fire**	20
Health and fitness	69	**Substance use**	19
Nutrition	57	**People with disabilities**	18
Insurance	54	**Quality of health care**	16
Children and teens	52	**Personal goals and intentions**	14
Pay, wages and income	52	**Elderly and aging**	13
Mental health	48	**Pharmacy and prescriptions**	12
Crime and safety	41	**Equity, diversity and inclusion**	10

Housing	40	Sanitation of public spaces	10
Availability of providers	37	Political concerns	9
Community	27	Transportation	8
Work / life balance	23	Relocation	7
Homeless	22	Alternative care	5

SELECT ILLUSTRATIVE COMMENTS

"I wish we could afford insurance for me. I love that my kids are covered. It would be wonderful if I could afford to get a family gym membership."

"Affordable health care! The housing crisis has made it impossible for our kids to move out after reaching adulthood. Because they are living with us we claim them as dependents, they DO NOT pay rent or utilities, but their income counts against us when filling for insurance assistance."

"Reduce how much two parents have to work to make ends meet. Reduced childcare costs. More kid and family-oriented programs and activities."

"Reduce the cost of services. My copays, coinsurance, and deductibles are too high. We do not follow all medical advice due to cost and fear the cost of emergencies."

"Not having to struggle to make ends meet. Stress of no or not enough money really has brought our immune systems down."

"Food prices are overall too expensive. More available farm fresh ingredients for affordable prices."

"Being able to live our lives back to what once was considered "normal". The mental health of our children, elderly and individuals that have disabilities have had a rough time. Quality of life is not being able to be lived to the fullest extent. Which in turn causes more crisis more mental health to be on the rise. Families going though rough times causing people to turn to substance abuse. The rise of domestic abuse/violence. Stressing about paying bills keeping roofs over everyone's heads. The cost of housing making it damn near impossible for someone who works full time & more than min wage to survive. Lack of child care availability for people who HAVE to work and let alone the cost. You have to choose to kill yourself working 40+ hours a week or multiple jobs to keep your family safe and healthy but then you are paying a TON of money on childcare. Food and other things have gone up in price it's a never-ending cycle. Stress, anxiety, depression, etc. and lack of being with your family."

"Quality and educated physicians that READ and LISTEN to their patients and are not quick to judge or assume until they thoroughly understand the history of their patient."

“Have doctors that actually care and treat people instead of throwing medications at them for bandaids. I have kids with various issues…f it’s not COVID they don’t want to help or refer you. They don’t take the time to listen and treat. It’s frustrating for those of us that pay for insurance and co pays to have to repeat the process over and over.” (detail redacted to protect anonymity)

“More sidewalks in lower income neighborhoods so people can safely walk the neighborhood with family.”

“More exercise trails, bike lanes and sidewalks that connect to parks and healthy eating establishments.”

“More year-round access to healthy food and more healthy restaurants. (Diggin Living, the farmers market etc are good, but either close early, aren't available year-round, or have limited selection).”

“More opportunities for youth, improved hours for childcare and activities, and ability to access health services when it's actually needed and not two years later.”

“Let childcare services go back to normal so that I can get care. State mandates have forced many to close down and have made it impossible to find workers. One center I really wanted to go to is closing with a long waiting list because it cannot find worker “qualified” enough to meet center requirements of certification.”

“More available and affordable, quality, reliable drop-in childcare facilities.”

“More childcare providers! I’ve been wait listed for over a year at SIX places!”

“Better income to match rising cost of living AND including health insurance with inclusive coverage with actual affordable copays and deductibles & out of pocket maximums that don't start over with every calendar year compounding/adding to the multiple previous years' medical related debt.”

“More money. Getting paid fairly. I feel like I’m underpaid. I can barely afford to keep the roof over my head. I don’t make much, work hard, go to school full time and still have to pay rent on time, pay bills on time, buy food to keep our bellies full. It’s extremely stressful not being paid enough.”

“More access to affordable healthcare and mental health services that are not reliant on prescription medications.”

“Accessible mental health services and support for behavioral/learning issues.”

“Provide more drug and mental health treatment for our community at large.”

“Better infrastructure to prevent wildfires and alert residents of wildfires. More infrastructure to house citizens during wildfires or earthquake. More treatment services for mental healthcare and drug addiction. BIGGER COUNTY JAIL. More mid-level income housing (not just low-income housing.) Homeless resources such as monitored\structured tent encampments.”

“Clean up public areas. Clean up our parks so they feel safe.”

“For our community, access to affordable housing, food and transportation. Access to alcohol and drug treatment. Mental health counseling.”

“Having a provider that listens and helps you understand what may be going on and how to correct it. Having a provider that doesn’t make snap diagnoses or judgements before even looking at an issue. Being able to discuss more than one (maybe 2) concerns at an appointment with a PCP. Better support in services like nutrition, exercise.”

“We need more medical doctors of every kind close to our home. We have to drive an hour or more to see a doctor or have inpatient surgical procedures. It's getting harder to make the trips.”

“More outdoor activities and events that help bring the community together.”

“A closer "rec-center" to provide indoor exercise and wellness classes that is offered at free-reduced rates for residents.”

“Places/activities to spend time with family outdoors where I don't have to wonder if there are needles in the grass and who will approach us.”

“Fortunately we have the means that we can join private health clubs, however, I think our community is in great need of a quality indoor outdoor pool and good quality community centers.”

“A city that is walkable. Medford caring about the experience of its constituents. Most humans can walk, but we don't have sidewalks in a lot of areas, we don't have food near to many residential areas (within walking distance). East Medford is only residential.”

“More accessible local hiking/ walking trails (in town, near town) without having to drive somewhere.”

“Flexible work schedule to be able to participate in the lives of my children during the day. It would be a dream to be able to spend time with them after school or to be able to do recreational activities in nature with them but working 8-5 makes it nearly impossible.”

“More time off! It's always about work which is no way to live and hard on our children.”

“Reconsidering quarantines for Covid exposures. There’s a lot of school closures, and it’s not super hard for my family but has had many negative impacts for kids in our schools.”

“The end of Covid and clear instructions for what really works for prevention With data to prove it. We have been told so many things of what to do and what not to do and none of it seems to be consistent. Now we are maskless and many people are not vaccinated. What do we do that works?”

“To be able to help with the homeless situation. This topic makes me worry about the health of our community.”

“Resources for full time caregivers of family members.”

“Resources for housebound and disabled persons.”

“The cost of health care is prohibitive. Basically, we spend our money on insurance and there is not much left over for actual health care. It has really gotten ridiculous and going in for medical care is definitely the last result - unless it is a broken bone or something immediate like that. So to answer the question, more focus and emphasis on prophylactic care.”

"Improve alternative ways to keep people from flooding the ER and keeping it for actual emergencies. Home visits and urgent care facilities."

"More pharmacy options, quicker turn-around time at pharmacy, better communication between dr office and pharmacy."

"The lack of diversity in the Rogue Valley is a problem. It is improving slowly, but is still lacking. The lack of diversity is due to the prevalent racial attitudes that have been a part of this valley and state since the beginning."

"We lost our home in the Almeda fire and my children have some anxiety and PTSD from it. They do not want to see a counselor because according to my kids there aren't any Latinx counselors who would understand them. They have both seen a counselor but both of them had a Caucasian counselor and they did not like the lack of connection so they both decided to no continue with mental health counseling."

"Better tolerance of economic and educational diversity."

Spanish Survey			
Total responses received	26	**Responses with no concern listed**	2
AREAS OF CONCERN FOR SELF AND FAMILY			
Economic concerns	11	**Elderly and aging**	1
Access to health care	10	**Mental Health**	1
Equity, diversity and inclusion	6	**Nutrition**	1
Programs, services and support	5	**People with disabilities**	1
Work / life balance	3	**Substance use**	1
Insurance	2	**Transportation**	1
Children and teens	2	**Elderly and aging**	1
Alternative care	1	**Pharmacy and prescriptions**	1

SELECT ILLUSTRATIVE COMMENTS

"More aid programs for Hispanics."

"More access to mental health services."

"More services at zero cost."

"Preventive alternative medicine."

"Fewer neighbors using drugs."

"Being able to obtain health insurance at an affordable cost."

"That the formula for living was to work to live instead of living just to work."

"That my son who is differently abled had access to all the services he needs to be successful in his life in addition to that we lived in a community that was truly inclusive and equitable for all."

"That health services of all kinds are affordable for low incomes. Access to medicines for chronic diseases such as diabetes."

"That if the prices of health services, especially dental, were not so expensive, it would be better for the community."

"I feel that I am fine with my family, only that I would like the rent to not be so expensive."

"Have more payment options to go to the doctor."

"Transportation for the elderly."

Question 41. What one thing could be done to improve the overall health and quality of life in Jackson and Josephine Counties?

English Survey			
Total responses received	769	**Responses with no concern listed**	44
IMPROVING THE HEALTH AND VITALITY OF OUR COMMUNITY			
Homelessness & housing	187	**Education**	22
Mental health	181	**Vaccination**	22
Substance use	119	**Air quality, fires and smoke**	20
Access to care	113	**Transportation**	20
Affordability	89	**Health and fitness**	19
Crime and safety	51	**Quality of health care**	17

Outdoor spaces	54	Multicultural inclusivity	16
Children and teens	48	Elderly and aging	14
Vulnerable citizens	44	Personal accountability	14
Quality of life	42	Marijuana/cannabis industry	10
Activities	42	Sanitation	10
Political	35	Community	9
COVID-related	35	Hospital	7
Availability of providers	32	Dental	6
Nutrition	24	LGBTQIA+	4
Compassion and humanity	23	Pharmacies and prescriptions	4

SELECT ILLUSTRATIVE COMMENTS

"We need to actively address homelessness and un-affordability of housing."

"Address the confluence of drug misuse, child abuse, criminal activity, health status and unaffordable housing realities."

"There are so many other places that are handling homelessness, substance abuse, mental health, etc. in much more compassionate and proactive ways. Here it seems there is an Us vs Them mentality and criminalization of people who are genuinely struggling. Life can be hard - we should foster more understanding and empathy in our community and take action to lift others up in genuine ways. It would benefit Everyone!"

"Affordable housing, access to drug and addiction services, homeless advocates, more mental health services, an acute care rehab facility."

"Here in the Rogue Valley will need a whole lot more drug & alcohol treatment programs for folks who are basically indigent. If I wanted treatment, I could pay for it, but most of the folks who need it can't afford it."

"Have better health and mental health coverage and access. Have housing shelters for homeless. Start caring more about people suffering from hardships and less about appealing to political agendas."

“It would be great if we could find somewhere else for homeless people to go and not encourage tent camps. The amount of drugs in our town is sickening and its not an environmental I want my children growing up in. It's sad that I can't take my kids to certain parks because of the presence of homeless and drug addicts. Wish there was a better solution for that population.”

“More access and resources for mental health/substance abuse to prevent homelessness, and/or help facilitate the unhoused into society.”

“1) stable housing for everyone 2) reduce poverty. I'm a teacher and my students are so very poor. It impacts their education almost daily.”

“Healthcare and Mental Healthcare for low-income people/families. And, of course, more affordable housing options. Affordable and high-quality childcare for working families. The more people are supported by the community, the more they will thrive. The less we do, the worse it will get. It's actually quite simple! And, yes, we are willing to pay more in taxes to help make those services available (as long as there is a well-funded effort to stop people who criminally take benefits meant for others.”

“More accessibility. Many of us feel that we don’t matter in our own community because these programs, offices and services that are supposed to be there for us are entirely inaccessible to even START using, let alone how long it takes to get through the system and actually get help. The housing commission had over a two year wait during the time we needed it most, we have insurance, yet have been unable to find appropriate care or a primary doctor who actually cares about our health and listens to us instead of trying their best to get us out the door quicker. The entire “services” system is broken and favors those who don’t need any more help to access their services.”

“More comprehensive treatment for addiction disorders and mental health disorders, which often go hand-in-hand. It seems that most of the violence, crime and general misery in the community are fundamentally due to untreated mental health and substance abuse disorders. We need residential and truly accessible outpatient treatment for unhoused, uninsured people. I'm willing to pay tax dollars for it.”

“More programs to help people who are living in poverty, struggling with mental health and addiction issues, have housing and food insecurity. The smoky summers affect all of our health as well, but I don't know how that changes.”

“Mental health and substance abuse programs with little to no cost to the individual. Community sponsored wellness.”

“I'm a middle school teacher, and it would be beneficial to have mental health services available to the students. We have a counselor and a therapist, but they are over booked and there are students who need to talk to a trained adult but can't.”

“Create more community resources for Mental Health, create more jobs, pay people enough to actually make a living. Jackson and Josephine counties are so behind in caring for their own. I believe the political environment right now makes things 1000000% worse.”

“Improved access to care for underserved communities (LGBT, BIPOC, those with mental health issues and those with socio-economic challenges.”

"More services for the issues the community is having. WE are so desperate for Mental Health and Addiction services and the providers we have right now are just not meeting the needs. I have my child in a virtual intensive outpatient program and am getting better services virtually than I have ever found in my community. That should not be the case."

"More services for the vulnerable populations, marginalized populations, etc. Resources and funding need to go to supporting more services, including mental health!"

"More mental health services and substance use help. More resources for people who are homeless. The services are limited here and they all seem to be full. There is no solution to helping the homeless, mental health, or substance use."

"Better collaboration between city/governance, MPD/JC Sherriffs, community-based organizations for mental health and houseless neighbors."

"Healthcare is impossible to find as a middle-class family. All services are directed towards low-income. We are penalized for keeping our heads above water. The socialization of healthcare has removed affordable options for working families while creating a vacuum that keeps low-income families dependent on government assistance. The housing crisis is compounding the issue."

"More primary care physicians as well as specialists. Access to healthcare is a barrier for many. Access includes, transportation, childcare, affordability, availability of services."

"Better access to resources for families in need. Recognizing that $20 an hour is barely attainable and still poverty."

"Bigger and more emergency rooms in our hospitals. Hospital expansion, need more rooms available."

"Increase resources to Josephine county. Health care resources seem to be Jackson centric. Often I hear "all you have to do is go to Medford". That is a reasonable option, but finding the resources (time, gas, etc.) is difficult."

"Make health care and dental care affordable to people who do not qualify for OHP because we make just a little too much. I'm single and I live alone. Consequently, that supposedly makes me more successful? I pay all of my bills with no help from a spouse or roommate. I have zero extra Money after living expenses, car payment, etc. no ability to save money. We are barely surviving."

"Less allopathic clinics and more personalized care clinics that treat the whole body not just the symptoms like allopathic clinics do. Equal access to doctors that want to fix the root causes not mask symptoms with medication."

"More availability for care for the underprivileged and seniors with limited means, clinics, urgent care, home visits for elderly."

"More senior groups for socialization- I dont like the things done or offered at Medford and they also charge money which is difficult for some seniors."

"Opportunities for events that are free or low cost that bring the community together, like the Pear [Blossom] Festival."

"Take control of the drug problem. Starting there will decrease some of the other crime/negative behaviors within the communities."

"Cleaning up Bear Creek pathway. We moved here in 2020, and we are hesitant to walk along this once beautiful pathway!"

"More green spaces, more substance abuse treatment options, greater enforcement of greenway for increased safety, community offerings for education on healthy living i.e. cooking, food choices, movement, personal growth."

"More health care in rural medically underserved areas. Get rid of the illegal cannabis growers and all that comes with them, including unsanitary living conditions for workers, and human trafficking."

"More childcare options, more affordable childcare, safety of the greenway, keeping parks safe and clean so we can feel comfortable taking our children there."

"More public transportation options with longer service times Monday through Friday. Better bike paths and bike lanes through both counties."

"Affordability of healthy food options. More recreation opportunities for adults and kids in places outside the city of Medford."

"Child care, family friendly parks and activities, healthy foods, update old buildings, cultural events."

"More outdoor, recreational activities for families, concerts in the park, skating rink (both types), group walks or group exercise classes."

"Clean up the greenway so we can all use it safely as well as: improve public transportation options, increase community events."

"Transportation to and from appointments, options for child care, more education and understanding and access to healthy foods and eating behaviors."

"Getting families more involved in each other's lives. To many parents are not interested in their kids' lives. Life is too busy!"

"Get childcare centers what they need! My friend who owns a childcare center has been trying for years to help the state and lawmakers make safe and lasting changes as it pertains to rules and regulations for centers. No changes have been implemented." Business name redacted to preserve confidentiality.

"We will significantly reduce fees for elderly care services, increase the number of elderly care service centers, and improve the living environment of communities. We will increase support for the living expenses of people with special difficulties."

"Allow minorities a seat on Boards, Commissions, to own businesses and a 'seat at the table'."

"A genuine and concerted effort to increase compassion and services for high risk groups in our valley!"

"More providers that will accept patients. In the last 2+ years providers have either retired or left Jackson County leaving patients struggling to find new primary care physicians etc. Once they find someone they still cannot get in to see that person for up to 6 months or more. Patients also cannot get in for other types of appointments (i.e. Imaging) for several weeks to months depending on what is needed."

"Access to quality MD's that actually want to care for patient - especially need Internal Medicine providers in Grants Pass area."

"More PCPs available in Ashland. Pediatric office in Ashland. MyChart is a great tool but it takes so long to get a response to medical questions. Seems too much is being demanded of doctors (maybe too many patients) and the doctor doesn't have time to respond."

"We need more doctors. We need better access to mental health care. We need more resources for homeless individuals. And more drug counseling/counselors."

"More investment in keeping primary care providers in our community, better job at attracting medical specialties including endocrinology and psychiatry (particularly for children)."

"The education of adults to help make them more aware of sociological and economic divides and ways to unite a community rather than divide it."

"More community education on preventative health care and education on what actually constitutes a Emergency Department visit. Too often people overuse and abuse the hospital for their care needs that could be met in a clinic or urgent care setting."

"Better control of wildfires in and around [the valley]. The smoke in the summer is horrible, unhealthy and causes the quality of life here to get horrible in the summer. We end up having to stay indoors for months!"

"These counties provide a plethora of areas that support overall health and quality of life. I believe I would focus efforts on seniors in rural areas who do not have the same access as those who are active and can get about by vehicle or family. Maybe a program that provides free Uber or Lyft services to the movies or downtown would be a valuable contribution. Much is done here for children, but I don't see that similar programs are available for older folks who cannot get around. They count, too."

"More investment in infrastructure for bike commuting, to make it easier and safer to adopt."

"More public transportation options with longer service times Monday through Friday. Better bike paths and bike lanes through both counties."

"More focus, education and access to good foods, exercise, and wellness/ depression treatment/ anxiety management and substance use disorders."

"In addition to improving services for BIPOC and LGBTQ+ communities, I've also had difficulty with certain providers, so improving their customer service voices and reducing the aura of superiority exuded in certain clinics."

"Treat people like humans. Not nuisances. Actually treat people with the intent to help not bandaid. People are busy and we don't have time to force doctors to do their jobs. Help the first time when we ask for help or we simply give up due to time, money and patience."

"Practitioners who are actually available AND LISTEN to you and make you feel like they CARE and CAN help you with your issues of concern... not a 3-minute drive by appointment after waiting weeks to get in and then they don't even really help the situation and if you call back for additional follow up you are back in the same boat..."

"More tolerance and understanding for people of diverse cultures and ethnicities."

"Health services for the homeless and better services for people of color."

"More racially diverse nurses, doctors and staffing."

"More funding for social/community events that are intentionally inclusive and diverse."

"More options for elderly that do not qualify for OHP who have no place to live."

"Perhaps looking in on seniors. Checking in on our more fragile senior neighbors."

"Remove illegal marijuana grows that consume water needed by all."

"Get rid of marijuana farms as I think they are a gate way to the overall substance abuse in the Valley."

"Create programs to support middle-class hard-working families be able to thrive."

"Bigger and more emergency rooms in our hospitals. Hospital expansion; need more rooms available."

"Improve access to health care: Reopen urgent cares. Fully staff hospitals and clinics. Fully staff nursing homes."

"Provide low-income healthcare and dental."

"Pharmacies that have faster and better service."

"More specialty doctors. Doctors that stay in the area. Lowering prescription prices."

Spanish Survey			
Total responses received	24	**Responses with no concern listed**	1
IMPROVING THE HEALTH AND VITALITY OF OUR COMMUNITY			
Access to care	14	**Compassion and humanity**	2
Spanish language access	8	**Community**	2
Vulnerable populations	8	**Health and fitness**	2

Affordability	5	Alternative medicine	1
Nutrition	3	Crime and safety	1
Outdoor spaces	3	Pharmacies and prescriptions	1

"Escorts for appointments."

"How to understand the instructions for surgery."

"Interpreters."

"Open centers for families with activities. For example, we had the trampoline park and they removed it. It's fun for everyone and it helps to be physically active."

"Probably more help with food."

"Defund the police, use savings to fund CAHOOTS mobile health crisis response model."

"Having programs to help Latinos in Spanish."

"Talk more about nutrition."

"Make healthy food accessible to those with little money."

"Accessible alternative preventive medicine."

"Plan to improve the costs or lower the costs of health services, for example, dental."

"Plan to guide the community on how to have a healthier life, providing more exercise equipment in all public parks. And promote how to eat healthier."

"Support programs to be able to acquire medicines at affordable prices."

"Security, help for drug addicts. There is a lot of homelessness and the streets are unsafe. Access to health care."

"Try to ensure that the homeless have a safe haven and do not walk the streets."

Community Health Survey Questions

2022 Community Health Needs Assessment (CHNA) Survey

Asante and Providence Health & Services would like to hear from you.

Please fill out this survey to let us know what is most important to you and your family. Your responses will also help us understand how we can support the community we serve.

Please answer each question as best you can and feel free to skip questions you do not want to answer. Your answers will be kept private.

Thank you.

Health Care

1. Do you have health coverage or insurance?
   - ❑ Yes
   - ❑ No **(If no, skip to question 3)**

2. What kind of health coverage or insurance do you have? **Check all that apply.**
   - ❑ Medicaid
   - ❑ Medicare
   - ❑ VA, TRICARE or other military health care
   - ❑ Indian Health Service (IHS)
   - ❑ I have private coverage through an employer or family member's employer
   - ❑ A private plan that I pay for myself
   - ❑ Other________________________________
   - ❑ I do not have any health insurance now
   - ❑ I do not know

3. If you do <u>not</u> have health coverage or insurance, what are the main reasons why? **Check all that apply.**
   - ❑ It costs too much
   - ❑ I do not think I need insurance
   - ❑ I am waiting to get coverage through a job
   - ❑ Signing up for insurance is too confusing
   - ❑ I have not had time to do it
   - ❑ Other______________________________

4. Have you or anyone in your household needed health care in the last year?
   - ❑ Yes
   - ❑ No (If no, skip to question 6)

5. Did you get all the health care you needed? **Check all that apply.**
   - ❑ We got all the care we needed
   - ❑ We got some but not all the care we needed
   - ❑ We had to delay getting the care we needed
   - ❑ We got no care at all
   - ❑ I do not know

6. For the <u>most recent time</u> you or anyone in your household put off or went without health care, what were the reasons? **Check all that apply.**
   - ❑ Cost

- ❑ Not having a primary health care provider
- ❑ Not knowing where to go
- ❑ Could not get an appointment soon enough

- ❑ Clinic is not open when I can go
- ❑ Needed childcare
- ❑ Needed transportation
- ❑ Not having a health care provider that speaks my language
- ❑ Not having a provider that understands my needs
- ❑ COVID-19 (coronavirus): appointment cancellation, concern of infection, or other related concerns
- ❑ Other reasons___________________________________
- ❑ Not applicable

7. A primary health care provider is the person you see if you need a health check-up, want advice about a health problem, or get sick or hurt. Do you have a primary care provider?
   - ❑ Yes
   - ❑ No
8. Have you ever been told by any health care professional that you have any of the following? **Check all that apply.**
   - ❑ Diabetes or high blood sugar
   - ❑ Asthma
   - ❑ High blood pressure
   - ❑ High cholesterol
   - ❑ Heart disease
   - ❑ Cancer
   - ❑ Depression
   - ❑ Post-traumatic stress disorder (PTSD)
   - ❑ Anxiety
   - ❑ Substance use disorder
   - ❑ Another ongoing health condition
   ____

9. In the last year, did you receive care using any of the following?
   - ❑ Urgent care
   - ❑ Emergency room
   - ❑ Telemedicine (video visit)
10. In the last year, did you need counseling or mental health treatment?
    - ❑ Yes
    - ❑ No **(If no, skip to question 12)**
11. Did you get all the counseling or mental health care you needed?
    - ❑ Yes
    - ❑ No (Please check all the types of counseling or mental health care you did not receive)
      - ❑ Support for a personal problem

- ❑ Treatment for a mental health condition like PTSD, depression, or anxiety
- ❑ Counseling to quit tobacco, alcohol, or drug use
- ❑ Other kinds of care

12. In the last year, have you or anyone in your household had concerns about alcohol, tobacco, or substance use?
    - ❑ Yes
    - ❑ No **(If no, skip to question 14)**

13. Were you able to get the help you needed with alcohol, tobacco, or substance use? **Place a checkmark in the box below.**

Health Service	Yes	No	Not Applicable
Smoking cessation program			
Alcohol treatment program			
Medication-assisted treatment program (for example Suboxone)			
Substance use disorder counseling and treatment (not including alcohol)			

Health & Lifestyle

14. How would you rate your overall physical health?
    - ❑ Excellent
    - ❑ Very good
    - ❑ Good
    - ❑ Fair
    - ❑ Poor
15. How would you rate your overall mental health?
    - ❑ Excellent
    - ❑ Very good
    - ❑ Good
    - ❑ Fair
    - ❑ Poor
16. In the last year, how often did you feel socially isolated or experience loneliness?
    - ❑ All of the time
    - ❑ Most of the time
    - ❑ Some of the time
    - ❑ None of the time

17. How often do you have someone available to do each of the following?

Love you and make you feel wanted

- ❑ All of the time
- ❑ Most of the time
- ❑ Some of the time
- ❑ None of the time

Give you good advice about a crisis

- ❑ All of the time
- ❑ Most of the time
- ❑ Some of the time
- ❑ None of the time

Get together for relaxation

- ❑ All of the time
- ❑ Most of the time
- ❑ Some of the time
- ❑ None of the time

Confide in or talk to about your problems

- ❑ All of the time
- ❑ Most of the time
- ❑ Some of the time
- ❑ None of the time

Help you if you became suddenly ill or disabled

- ❑ All of the time
- ❑ Most of the time
- ❑ Some of the time
- ❑ None of the time

18. In the last year, did you participate in a religious community? **(Check all that apply)**

- ❑ Christianity
- ❑ Islam
- ❑ Buddhism
- ❑ Judaism
- ❑ Other: _________________
- ❑ No, I am atheist or agnostic

19. During the last two weeks, how often have you felt the following:

	Not at all	Several days	Over half of the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Feeling nervous, anxious, or on edge				
Not being able to stop worrying				

20. How often have you had these hard times or traumatic events in your life?

Life changing illness or injury

- ❑ Not at all
- ❑ Some of the time
- ❑ A lot

Neglect of any kind

- ❑ Not at all
- ❑ Some of the time
- ❑ A lot

Lived with someone with mental illness

- ❑ Not at all
- ❑ Some of the time
- ❑ A lot

Lived with someone with substance abuse issues

- ❑ Not at all
- ❑ Some of the time
- ❑ A lot

Witnessed or experienced violence

- ❑ Not at all
- ❑ Some of the time
- ❑ A lot

Made to do something sexual that you did not want to do

- ❑ Not at all
- ❑ Some of the time
- ❑ A lot

Physically hurt or threatened by an intimate partner or parent/caregiver

- ❑ Not at all
- ❑ Some of the time
- ❑ A lot

Abuse of any kind

- ❑ Not at all
- ❑ Some of the time
- ❑ A lot

Parents were separated or divorced during your childhood (ages newborn to 18)

- ❑ Not at all
- ❑ Some of the time

- ❑ A lot

A personal suicide attempt

- ❑ Not at all
- ❑ Some of the time
- ❑ A lot

A suicide or suicide attempt by a close friend or family member

- ❑ Not at all
- ❑ Some of the time
- ❑ A lot

Unexpected death of a loved one

- ❑ Not at all
- ❑ Some of the time
- ❑ A lot

Another traumatic event

- ❑ Not at all
- ❑ Some of the time
- ❑ A lot

21. Do you have any children (under 18 years of age)?
    - ❑ Yes
    - ❑ No (If no, skip to question 23)
22. Have you ever been told by a health care professional that any of your children have the following? Check all that apply.
    - ❑ Diabetes or high blood sugar
    - ❑ Asthma
    - ❑ A behavioral or mental health diagnosis (such as depression, anxiety, or ADHD)
    - ❑ A developmental delay or a learning disability (such as autism or dyslexia)
    - ❑ Post-traumatic stress disorder (PTSD)
    - ❑ Another ongoing health condition: ____________________________________

23. The following questions are about where you live. **Please choose the number that best represents your opinion of each statement. If you do not know, please respond "DK".**

Statements	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Do not Know
My community has health care options available. Think about the cost and quality of care, distance you need to travel, and availability of appointments.	1	2	3	4	5	DK
My community is a good place to raise children. Think about the quality and safety of school and childcare, after-school programs, and places to play in your neighborhood.	1	2	3	4	5	DK
My community is a good place to grow old. Think about senior housing, transportation to medical services, access to shopping centers and businesses, recreation, and services for seniors.	1	2	3	4	5	DK
I feel safe in my home. Think about everything that makes you feel safe, such as neighbors, presence of law enforcement, etc. and everything that could make you feel unsafe at home, including family violence, robbery, housing conditions, etc.	1	2	3	4	5	DK
My community feels safe. Think about how safe you feel in and around your neighborhood, schools, playgrounds, parks, businesses, and shopping centers.	1	2	3	4	5	DK
I feel prepared for an emergency. Think about everything that makes you feel prepared, such as toolkits, smoke alarms, fire extinguishers, etc.	1	2	3	4	5	DK
People of all races, ethnicities, backgrounds, and beliefs in my community are treated fairly. Think about discrimination and programs that work to increase diversity.	1	2	3	4	5	DK
People in my community can access mental health services and substance use disorder treatment.	1	2	3	4	5	DK

Think about counseling services, support groups, and substance use disorder counseling and treatment centers.						
Healthy food is available in my community. Think about restaurants, grocery stores, supermarkets, corner stores, and farmers' markets that sell fresh fruits, vegetables, lean proteins/meats and other healthy options.	1	2	3	4	5	DK
There are places to be physically active near my home. Think about parks, trails, places to walk and playgrounds.	1	2	3	4	5	DK
I have enough financial resources to meet my basic needs. Think about income for purchasing food, clothing, housing, and utilities.	1	2	3	4	5	DK

Adapted from Lake County Community Health Assessment, 2018

Would you like to tell us more about any of your responses above?

About You and Your Family

24. What ZIP code do you live in? _____________
25. What year were you born? __________________
26. Are you Hispanic or Latino/Latina/Latinx?
    - ❑ Yes
    - ❑ No
27. What is your race? Check all that apply.
    - ❑ White
    - ❑ Black or African American
    - ❑ Asian
    - ❑ Native Hawaiian or other Pacific Islander
    - ❑ American Indian or Alaska Native
    - ❑ Middle Eastern/North African
    - ❑ Do not know/not sure
    - ❑ Prefer not to answer
28. What is your gender?
    - ❑ Female
    - ❑ Male
    - ❑ Transgender
    - ❑ Gender non-binary
    - ❑ Gender non-conforming
    - ❑ Choose not to answer
    - ❑ Other ________________________

29. What is your sexual orientation?
- ❑ Asexual
- ❑ Bisexual
- ❑ Gay
- ❑ Heterosexual or straight
- ❑ Lesbian
- ❑ Pansexual
- ❑ Queer
- ❑ Choose not to answer
- ❑ Other _________________

30. How many people currently live in your home? Count adults, seniors, and children under 18? Number of adults (18 to 65 years) ___________

Number of seniors (over age 65) ____________

Number of children (birth to 18) ____________

31. What is your gross household income (the amount before taxes and deductions are taken out) for last year (2021)? Your best guess is fine.
- ❑ $0
- ❑ $1 to $10,000
- ❑ $10,001 to $20,000
- ❑ $20,001 to $30,000
- ❑ $30,001 to $40,000
- ❑ $40,001 to $50,000
- ❑ $50,001 to $60,000
- ❑ $60,001 to $70,000
- ❑ $70,001 to $80,000
- ❑ $80,001 to $90,000
- ❑ $90,001 to $100,000
- ❑ $100,001 or more

32. What is your current employment status?
- ❑ Employed full time (40 hours per week)
- ❑ Employed part time
- ❑ Seasonal, service industry, gig economy
- ❑ Self-employed
- ❑ Retired
- ❑ Unable to work due to illness, injury, or disability
- ❑ Homemaker or stay-at-home parent
- ❑ Student
- ❑ Unemployed

33. Do you work more than one job?
- ❑ Yes
- ❑ No (If no, skip to question 35)

34. Do you **have to** work more than one job to afford your living expenses?
- ❑ Yes
- ❑ No

35. Have you or someone in your household lost a job or hours due to COVID-19?

- ❑ Yes
- ❑ No

36. Which of the following best describes your housing situation today?
    - ❑ I have housing and **I am not** worried about losing it
    - ❑ I have housing, but **I am** worried about losing it
    - ❑ I do not have housing, and I am staying with friends or family
    - ❑ I am staying in a shelter
    - ❑ I am staying in my car or on the street
    - ❑ Other (tell us): _
37. Have you or someone in your household lost your housing due to COVID-19 or wildfires?
    - ❑ COVID-19
    - ❑ Wildfires
    - ❑ Not applicable
38. **In the last year**, have you or anyone in your household had to go without anything from this list because you couldn't afford it?

	Yes	No	Not Applicable
Food			
Utilities (water, electricity, heat)			
Transportation			
Clothing			
Personal hygiene items (soap, shampoo, toilet paper, feminine products, etc.)			
Stable housing or shelter			
Medical care			
Medicine			
Childcare			
Dental care			

Short Answers

39. What health services are needed but not available near where you live?
40. What one thing could be done to improve the health and quality of life for your family?
41. What one thing could be done to improve the overall health and quality of life in your community?

End of survey

If you would like to make a public comment about Providence or Asante's current CHNA and Community Health Improvement Plan, please contact kyle.roesler@providence.org or sheri.croy@asante.org.

Thank you for completing the 2022 Community Health Needs Assessment (CHNA) survey.

Appendix 2: Key Informant Survey Data

Key Informant Survey Results

Question 1. Prior to reviewing Asante Rogue Regional Medical Center's Community Health Improvement Plan, how aware were you of how the hospital is addressing each of the following needs in the community

2020-2022 CHIP Priorities	Not Aware At All	Somewhat Aware	Very Aware
Access to Healthcare	16%	63%	21%
Substance Abuse	26%	63%	11%
Mental Health	11%	47%	42%
Heart Disease and Stroke	16%	58%	26%
Infant Health	21%	63%	16%

Question 2. Overall, how would you rate Asante Rogue Regional Medical Center's effort to address these health needs in the community?

2020-2022 CHIP Priorities	Poor	Fair	Good	Very Good	Excellent
Access to Healthcare	0%	5.3%	47.4%	31.6%	10.5%
Substance Abuse	10.5%	36.8%	36.8%	15.8%	0%
Mental Health	5.3%	31.6%	31.6%	26.3%	5.3%
Heart Disease and Stroke	0%	0%	15.8%	47.4%	31.6%
Infant Health	0%	0%	47.4%	42.1%	10.5%

Question 3. What else could Asante Rogue Regional Medical Center do to improve access to health care in the community?

- Work better with residential programs to streamline services.

Question 4. What else could Asante Rogue Regional Medical Center do to improve substance abuse in the community?

- "Provide dual diagnosis treatment facility or collaborate with ones that exist.
- Collaborate with local homeless shelters and treatment facilities to provide mental and physical health care support."
- Support growth of programs and available beds to support those ready to change. Also ways to fund this and of course Bilingual support.
- Promote education with providers around stigma and shaming practices that many providers continue to carry that promote shame and despair adding to the stigma of these individuals in the community.
- The community is desperately in need of SUD treatment, including a Intensive Outpatient Program that is structured and progressive. Examples, treatment options M-Saturday. A good one (virtually out of area) that I have seen provides M-Friday treatment from 9-12 OR 4-7 and a Saturday 10-1 option and the client picks 3 days.

Question 5. What else could Asante Rogue Regional Medical Center do to improve mental health in the community?

No responses.

Question 6. What else could Asante Rogue Regional Medical Center do to improve heart disease and stroke in the community?

No responses.

Question 7. What else could Asante Rogue Regional Medical Center do to improve infant health in the community?

No responses.

Question 8. Prior to reviewing Providence Medford Medical Center's Community Health Improvement Plan, how aware were you of how the hospital is addressing each of the following needs in the community?

2020-2022 CHIP Priorities	Not Aware At All	Somewhat Aware	Very Aware
Social Determinants of Health	21%	53%	26%

Chronic Conditions	26%	53%	21%
Mental Health/Well-being and Substance Use Disorder	32%	47%	21%
Access to Care	16%	68%	16%

Question 9. Overall, how would you rate Providence Medford Medical Center's effort to address these health needs in the community?

2020-2022 CHIP Priorities	Poor	Fair	Good	Very Good	Excellent
Social Determinants of Health	0%	5.3%	79.0%	10.5%	5.26%
Chronic Conditions	0%	0%	73.7%	21.1%	5.26%
Mental Health/Well-being and Substance Use Disorder	5.3%	31.6%	42.1%	15.8%	5.3%
Access to Care	0%	0%	63.2%	26.3%	10.5%

Question 10. What else could Providence Medford Medical Center do to improve social determinants of health and well-being in the community?

- Some of these issues originate in the economic and cultural areas of our community. Businesses, educational organizations, food distribution, job training, economic development agencies all have a role to play in creating a healthy community.

Question 11. What else could Providence Medford Medical Center do to improve chronic conditions in the community?

No responses.

Question 12. What else could Providence Medford Medical Center do to improve behavioral health/well-being and substance use disorder in the community?

- Collaborate with other mental health providers to provide services mental health and substance abuse treatment.
- Bilingual resources and funding.

- Promote anti-stigma and language use to their providers. Many are shame based and believe that these issues are more character flaws instead of medical conditions and concerns.
- Providence does not have MH or SUD care, so starting any program would be a benefit to the community. Simply attending to patients with self-harm in the ER with a QMHP or higher would be a good start too. I recently was in their waiting room when a gentleman had flown in to seek care (bad advice from his mother), he was nicely dressed and clearly distraught. I could hear him on the phone with his mother discussing his MH and suicide ideologies, I don't know that anyone every connected with him. I mentioned it to the nurse, she said they were aware- yet he still sat there. He should have been made a priority as it was clear he was suicidal. Once he walks out the door, we don't know the outcomes and we've missed the opportunity. It was sad, and I understand we don't have resources locally, but we've got to use and try with what we do have.
- stated above
- How about a treatment facility for youth. There are no drug residential treatment facilities for youth in Jackson County.

Question 13. What else could Providence Medford Medical Center do to improve access to care in the community?

No responses.

Question 14. Who do you think is doing a good job serving the community in each of these areas? You can name up to 3 organizations for each identified need.

See Appendix 4 for a list of organizations serving the community.

Question 15. Both Asante Rogue Regional Medical Center and Providence Medford Medical Center aided in the COVID-19 response in our community.

The table below outlines some of the projects and initiatives each hospital undertook to support our community during the pandemic. *Please note they are listed in alphabetical, not rank, order.*

Please state your awareness of each of the following prior to participating in this survey.

For Asante Rogue Regional Medical Center:

	Not At All Aware	Somewhat Aware	Very Aware
Community education and outreach on preventing the spread of COVID-19.	11%	16%	74%
Community education on vaccine availability and safety.	5%	21%	74%
Drive-thru COVID-19 testing center.	5%	16%	79%

Drive-thru monoclonal antibody clinic.	42%	32%	26%
Hosted community vaccine clinic on the Asante campus.	11%	32%	58%
Participation in the community vaccine clinic at the Expo.	11%	16%	74%

For Providence Medford Medical Center:

	Not At All Aware	Somewhat Aware	Very Aware
Community education and outreach on preventing the spread of COVID-19.	5%	37%	53%
Community education on vaccine availability and safety.	26%	26%	42%
Drive-thru COVID-19 testing center.	32%	11%	53%
Hosted community vaccine clinics.	26%	26%	42%
Participation in the community vaccine clinic at the Expo.	5%	37%	53%

Question 16. Overall, how would you rate these hospitals' efforts to address COVID-19 in this community?

	Poor	Fair	Good	Very Good	Excellent
Asante Rogue Regional Medical Center	0%	0%	11%	42%	47%
Providence Medford Medical Center	0%	5%	26%	26%	37%

Question 17. What could these hospitals do to better address the COVID-19 pandemic locally?

Asante Rogue Regional Medical Center	• No responses
Providence Medford Medical Center	• No one knew they were doing anything. Asante was visible in the community and very active. No so Providence. They just are not very active in the community, this is probably because they are Portland centered.

Question 18. Is there any other health issue, that has not already been covered in this survey, that you feel is a major problem in this community?

No: 89%

Yes: 11%

What is the health issue? Please list only one health issue and the reason you feel this is a major problem in your community.

- Transportation creates barriers that do not allow patients to get the health care they need. Also the lack of bilingual staff. I am still surprised to go to places like Asante Primary care and having to be the one to step in to translate even though I am there as a patient because there was no one to translate even at check in.
- Easily accessible wraparound services for pregnant women and new moms--there is not enough support offered during this key period of development.

Question 19. Now that you've had a chance to consider the community health needs identified by our previous CHNA process, as well as identify a need you felt was missing, please help us rank the needs in OUR community. Consider the table of common needs below, please select the five most important issues that need to be addressed to make our community healthy. Again these needs are listed in alphabetical order. Please rank them from 1 to 5, with 1 being the highest priority in your opinion.

Answers	Count	Percentage
Homelessness/lack of safe, affordable housing	14	74%
Mental health	13	68%
Substance use disorder	9	47%
Affordable childcare and preschool	8	42%
Economic insecurity	6	32%
Access to health care services	5	26%
Access to safe, reliable, affordable transportation	4	21%
Aging problems	4	21%
Environmental concerns	4	21%
Job skills training	4	21%

Access to dental care	3	16%
Domestic violence, child abuse/neglect	3	16%
Chronic conditions: obesity, heart disease, stroke, and diabetes	2	11%
Community violence; lack of feeling safe	2	11%
Food insecurity	2	11%
Lack of community involvement and engagement	2	11%
Racism and discrimination	2	11%
Disability inclusion	1	5%
Few community building events	1	5%
Gun violence	1	5%
Maternal and infant health	1	5%
Opportunity gap in education	1	5%
Safe and accessible parks/recreation	1	5%
Safe streets for all users	1	5%
Other	1	5%

Question 20. Please choose the sector that most accurately describes your business or organization:

Answers	Count	Percentage
Business sector	0	0%
Government	4	21%
Education	3	16%
Faith-based/Religious	0	0%
Health care	4	21%
Industry	0	0%
Social services	8	42%

Question 21. Please list up to five types of minority or medically underserved populations served by your organization.

Individual Responses
Uninsured, Latinx, Houseless, Farmworkers

Spanish-speaking community, parents during pregnancy and early childhood, students at schools without a school-based health center
People with mental health conditions, family and friends affected by mental health
Migrant workers, homeless, African Americans
Low-income, single parents, at-risk youth, older adults, people with disabilities
LGBTQIA+, people with disabilities, people from racial or ethnic minority backgrounds, families experiencing SUD, families with mental health crises
Latin X, migrant workers, homeless population, low income, LGBTQIA+
Homeless, very low income, elderly who are on fixed incomes, POC, needing financial education/counseling
Homeless youth ages 10-17, transportation for youth, counseling services for youth & their families, drug addiction treatment facilities for youth
Hispanic, Native American
Developmentally disabled, mentally ill
Clients in need of behavioral health supports, adults with disabilities, older adults, older adults with cognitive impairments, adults with sensory impairments – sight, hearing
BIPOC, LGBTQAI, older folks, generational poverty white
Aging population, people with disabilities, mental/behavioral health of aging population, food insecurity of aging population and people with disabilities
Older adults on Medicare only, Latin X families, houseless individuals, children in low-income homes, chronically mentally ill

Question 22. For reporting purposes, only the name of your organization will appear in the next Community Health Needs Assessment report. How would you like your organization name to appear?

Individual Responses
La Clinica
United Way of Jackson County
Southern Oregon Success
Senior and Disability Services, Rogue Valley Council of Governments
Rogue Valley Family YMCA
Rogue Valley Council of Governments
Rogue River School District
Providence Medford Medical Center
Pathway Enterprises Inc.

National Alliance on Mental Illness Southern Oregon
Medford School District
Jackson County Mental Health
Heart with a Mission
Consumer Credit Counseling Service of Southern Oregon
City of Medford

Question 23. If you have any other comments that were not addressed in this survey, please feel free to share them below.

- I greatly appreciate the efforts of both Asante and Providence in caring for our community. I'm hoping that both will be very active in our region's effort to develop a Child Success Delivery System as proposed by former Governor Kitzhaber at the October meeting hosted by JRHA and Southern Oregon Success. We need to accelerate our work to provide support for every child and family to ensure all children have the opportunity to enter Kindergarten ready to thrive.
- I appreciate the opportunity for feedback. I understand we are a resource limited community, I think we do a great job with the resources we have. We have lot's of gaps and opportunity to grow.
- Hearts With A Mission has been serving homeless youth & their families for the last 14 years. We have provided over 2500 kids with safe housing while working on a safe exit. We are the ONLY youth shelter in Jackson County and would benefit from support from Asante & Providence. It is a preventive model to help youth not become chronically homes as adults. We also provide Transitional Living for youth 18-21 who are exiting Foster Care. It would be beneficial to provide preferential access when youth need emergency health care.

Key Informant Survey Questions

INTRODUCTION

Thank you for your participation in this online questionnaire.

This online questionnaire is part of a collaborative community health improvement effort between Asante and Providence and seeks to evaluate each organization's recent work around specific health issues. Your feedback is essential to helping our local hospitals meet federal regulations.

Asante and Providence are seeking the input of local professionals with this questionnaire. Your responses, along with those of other respondents, will be combined and not shared individually.

This online questionnaire should take approximately 15-20 minutes to complete.

As noted in the email you received, we ask that you first review the current activities that each hospital is working on as part of its Community Health Improvement Plan.

If you have not yet reviewed this information, please click on the link provided for each hospital to open the website in a new window and review the plan. Then, PLEASE RETURN TO THIS WINDOW TO COMPLETE THE SURVEY.

Asante Rogue Regional Medical Center (Jackson and Josephine County, Medford)

Providence Medford Medical Center (Jackson and Josephine County, Medford)

This part of the questionnaire pertains to Asante Rogue Regional Medical Center's previous community health needs assessment and community health implementation plan.

1. **Prior to reviewing Asante Rogue Regional Medical Center's Community Health Improvement Plan, how aware were you of how the hospital is addressing each of the following needs in the community**

	Very Aware	Somewhat Aware	Not At All Aware
Access to Health Care	3	2	1
Substance Abuse	3	2	1
Mental Health	3	2	1
Heart Disease and Stroke	3	2	1
Infant Health	3	2	1

2. **Overall, how would you rate Asante Rogue Regional Medical Center's effort to address these health needs in the community?**

	Excellent	Very Good	Good	Fair	Poor
Access to Health Care	5	4	3	2	1
Substance Abuse	5	4	3	2	1
Mental Health	5	4	3	2	1
Heart Disease and Stroke	5	4	3	2	1
Infant Health	5	4	3	2	1

3. **What else could Asante Rogue Regional Medical Center do to improve access to health care in the community?**

   ____

   ____

4. **What else could Asante Rogue Regional Medical Center do to improve substance abuse in the community?**

   ____

   ____

5. **What else could Asante Rogue Regional Medical Center do to improve mental health in the community?**

   ____
   ____

6. **What else could Asante Rogue Regional Medical Center do to improve heart disease and stroke in the community?**

   ____
   ____

7. **What else could Asante Rogue Regional Medical Center do to improve infant health in the community?**

   ____
   ____

This part of the questionnaire pertains to Providence Medford Medical Center's previous community health needs assessment and community health implementation plan.

8. **Prior to reviewing Providence Medford Medical Center's Community Health Improvement Plan, how aware were you of how the hospital is addressing each of the following needs in the community**

	Very Aware	Somewhat Aware	Not At All Aware
Social Determinants of Health and Well-being	3	2	1
Chronic Conditions	3	2	1
Behavioral Health/Well-being and Substance Use Disorder	3	2	1
Access to Care	3	2	1

9. **Overall, how would you rate Providence Medford Medical Center's effort to address these health needs in the community?**

	Excellent	Very Good	Good	Fair	Poor
Social Determinants of Health and Well-being	5	4	3	2	1
Chronic Conditions	5	4	3	2	1
Behavioral Health/Well-being and Substance Use Disorder	5	4	3	2	1
Access to Care	5	4	3	2	1

10. **What else could Providence Medford Medical Center do to improve social determinants of health and well-being in the community?**

    ____
    ____

11. **What else could Providence Medford Medical Center do to improve chronic conditions in the community?**

    ____
    ____

12. **What else could Providence Medford Medical Center do to improve behavioral health/well-being and substance use disorder in the community?**

    ____
    ____

13. **What else could Providence Medford Medical Center do to improve access to care in the community?**

    ____
    ____

14. **Who do you think is doing a good job serving the community in each of these areas? You can name up to 3 organizations for each identified need.** *Note the needs are in alphabetical, not rank order.*

Access to care			
Behavioral or mental health			
Chronic conditions			
Heart disease and stroke			
Infant health			
Social determinants of health and well-being			
Substance abuse			

15. **Both Asante Rogue Regional Medical Center and Providence Medford Medical Center aided in the COVID-19 response in our community.**

    The table below outlines some of the projects and initiatives each hospital undertook to support our community during the pandemic. *Please note they are listed in alphabetical, not rank, order.*

    Please state your awareness of each of the following prior to participating in this survey.

    For Asante Rogue Regional Medical Center:

	Very Aware	Somewhat Aware	Not At All Aware
Community education and outreach on preventing the spread of the virus.	3	2	1
Community education on vaccine availability and safety.	3	2	1
Drive-thru COVID-19 testing center.	3	2	1
Drive-thru monoclonal antibody clinic.	3	2	1
Hosted community vaccine clinic on the Asante campus.	3	2	1
Participation in the community vaccine clinic at the Expo.	3	2	1

For Providence Medford Medical Center:

	Very Aware	Somewhat Aware	Not At All Aware
	3	2	1
	3	2	1
	3	2	1
	3	2	1
	3	2	1
	3	2	1

16. Overall, how would you rate the hospitals' efforts to address this issue in this community?

	Excellent	Very Good	Good	Fair	Poor
Asante Rogue Regional Medical Center	5	4	3	2	1
Providence Medford Medical Center	5	4	3	2	1

11. What could these hospitals do to better address the COVID-19 pandemic locally?

Asante Rogue Regional Medical Center	
Providence Medford Medical Center	

17. **Is there any OTHER health issue, that has not already been covered in this survey, that you feel is a major problem in this community?** (Yes/No)

18. **What is that health issue? Please list only ONE health issue AND the reason that you feel this is a major problem in your community.**

____
____

Now that you've had a chance to consider the community health needs identified by our previous CHNA process, as well as identify a need you felt was missing, please help us rank the needs in OUR community. Consider the table of common needs below, please select the five most important issues that need to be addressed to make our community healthy. Again these needs are listed in alphabetical order. Please rank them from 1 to 5, with 1 being the highest priority in your opinion.			
	Access to health care services		Food insecurity
	Access to dental care		Gun violence
	Access to safe, reliable, affordable transportation		HIV/AIDS
	Affordable childcare and preschools		Homelessness/lack of safe, affordable housing
	Aging problems		Job skills training
	Bullying in schools		Lack of community involvement and engagement
	Chronic conditions: obesity, heart disease, stroke, and diabetes		Maternal and infant health

	Community violence; lack of feeling of safety		Mental health
	Disability inclusion		Opportunity gap in education (e.g. funding, staffing, support systems, etc. in schools)
	Domestic violence, child abuse/neglect		Racism and discrimination
	Economic insecurity (lack of living wage jobs and unemployment)		Safe and accessible parks/recreation
	Environmental concerns (e.g. climate change, fires/smoke, pollution)		Safe streets for all users (e.g. crosswalks, bike lanes, lighting, speed limits)
	Few community-building events (e.g. arts and cultural events)		Substance use disorder
	Other:		

DEMOGRAPHICS

The next questions are about your organization and are for classifying purposes only.

19. **Please choose the sector that most accurately describes your business or organization:**

    _____business sector (skip to question 22)

    _____government

    _____education

    _____faith-based / religious

    _____health care

    _____industry (skip to question 22)

    _____social service

20. **Please identify which of these populations are served by your organization:**

    Low-Income Residents (Yes/No)

Minority Populations (Yes/No)

Medically Underserved (Those experiencing health disparities or who are at risk of not receiving adequate medical care as a result of being uninsured/underinsured due to geographic, language, financial, or other barriers.) (Yes/No)

21. In the spaces below, please LIST up to 5 types of minority or medically underserved populations served by your organization.

Minority/Medically Underserved Population #1: ______________________________________

Minority/Medically Underserved Population #2: ______________________________________

Minority/Medically Underserved Population #3: ______________________________________

Minority/Medically Underserved Population #4: ______________________________________

Minority/Medically Underserved Population #5: ______________________________________

If all answers are "NO" skip to question 22.

2. For reporting purposes, ONLY the name of your organization will appear in the next Community Health Needs Assessment report. How would you like that to appear?

____

That's the last question. If you have any other comments that were not addressed in this survey, please feel free to share them below:

If you would like to review the complete findings from Asante and Providence's 2019 Community Health Needs Assessments, please use the links below.

Asante Ashland Community Hospital

Asante Rogue Regional Medical Center

Asante Three Rivers Medical Center

Providence Medford

If you'd like to provide public comment on the previous CHNA for any of our southern Oregon hospitals, please connect.

For Asante hospitals, email CHNA@asante.org.

For Providence Medford, email kyle.roesler@providence.org

Thank you very much for your time and cooperation. Your help and insight are greatly appreciated.

Appendix 3: Quantitative Data

POPULATION LEVEL DATA

Population Below 200% Federal Poverty Level

Indicator	Jackson County	Josephine County	Combined Broader Service Area	Combined High Need Service Area
Percent of Population Below 200% Federal Poverty Level Data Source: American Community Survey Year: 2019	36.3% (77,756 persons)	43.6% (37,050 persons)	31.8% (54,093 persons)	48.4% (60, 713 persons)

Language Proficiency

Indicator	Jackson County	Josephine County	Combined Broader Service Area	Combined High Need Service Area
Percent of Population Age 5+ Living in a Limited English-Speaking Household Data Source: American Community Survey Year: 2019	1.8% (3,731 persons)	0.5% (443 persons)	0.5% (999 persons)	2.4% (3,175 persons)

Percent of Population with A High School Education

Indicator	Jackson County	Josephine County	Combined Broader Service Area	Combined High Need Service Area
Percent of Population Age 25+ With at Least a High School Education Data Source: American Community Survey Year: 2019	90.1% (139,644 persons)	90.4% (57,651 persons)	92.5% (117,423 persons)	86.9% (79,872 persons)

Percent of Households Receiving SNAP Benefits

Indicator	Jackson County	Josephine County	Combined Broader Service Area	Combined High Need Service Area
Percent of Households Receiving Supplemental Assistance Program (SNAP) Benefits Data Source: American Community Survey Year: 2019	18.5% (16,343 persons)	23.2% (8,454 persons)	14.0% (10,790 persons)	27.9% (14,007 persons)

Asthma Prevalence

Indicator	Jackson County	Josephine County	Combined Broader Service Area	Combined High Need Service Area
Asthma Crude Prevalence Data Source: Behavioral Risk Factor Surveillance System Survey (BRFSS) Year: 2019	10.3%	10.7%	10.4%	11.4%

Obesity Prevalence

Indicator	Jackson County	Josephine County	Combined Broader Service Area	Combined High Need Service Area
Obesity Crude Prevalence Data Source: Behavioral Risk Factor Surveillance System Survey (BRFSS) Year: 2019	28.2%	32.8%	28.0%	30.9%

Tobacco Use

Indicator	Jackson County	Josephine County	Combined Broader Service Area	Combined High Need Service Area
Smoking Crude Prevalence	16.9%	18.8%	16.7%	21.1%

Data Source: Behavioral Risk Factor Surveillance System Survey (BRFSS) Year: 2019				

Alcohol Consumption

Indicator	Jackson County	Josephine County	Combined Broader Service Area	Combined High Need Service Area
Binge Drinking Crude Prevalence Data Source: Behavioral Risk Factor Surveillance System Survey (BRFSS) Year: 2019	16.5%	15.7%	16.4%	17.1%

Physical Inactivity

Indicator	Jackson County	Josephine County	Combined Broader Service Area	Combined High Need Service Area
Physical Inactivity Crude Prevalence Data Source: Behavioral Risk Factor Surveillance System Survey (BRFSS) Year: 2019	25.0%	29.9%	23.8%	28.7%

Diabetes Prevalence

Indicator	Jackson County	Josephine County	Combined Broader Service Area	Combined High Need Service Area
Diabetes Crude Prevalence Data Source: Behavioral Risk Factor Surveillance System Survey (BRFSS) Year: 2019	11.0%	13.0%	10.6%	11.0%

Life Expectancy at Birth

Indicator	Jackson County	Josephine County	Combined Broader Service Area	Combined High Need Service Area
Life Expectancy at Birth Data Source: CDC/National Center for Health Statistics Year:	79.1 years	76.8 years	-	-

Percentage of Veterans

Indicator	Jackson County	Josephine County	Combined Broader Service Area	Combined High Need Service Area
Population 18+ who are Veterans Data Source: American Community Survey Year: 2019	10.7% (18,404 persons)	12.7% (8,804 persons)	12.1% (16,548 persons)	10.4% (10,660 persons)

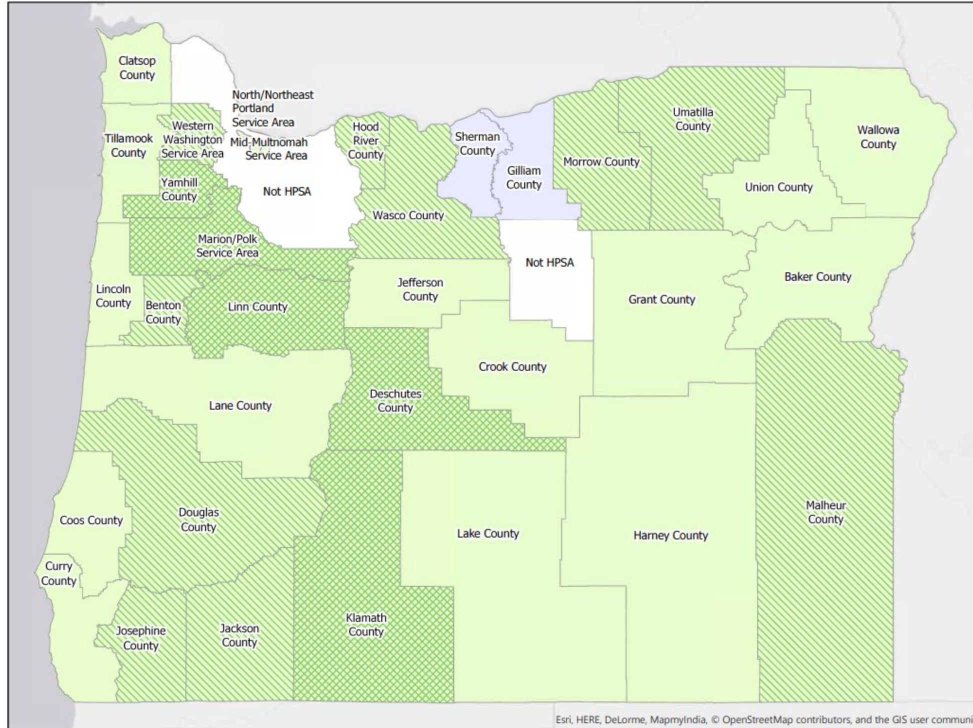
Households without Internet Access

Indicator	Jackson County	Josephine County	Combined Broader Service Area	Combined High Need Service Area
Households without Internet Access Data Source: American Community Survey Year: 2019	11.2% (9,852 households)	14.3% (5,206 households)	11.0% (8,218 households)	13.6% (6,840 households)

HEALTH PROFESSIONAL SHORTAGE AREA

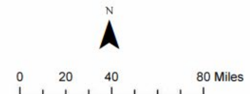
The Federal Health Resources and Services Administration (HRSA) designates Health Professional Shortage Areas HPSAs) as areas with a shortage of primary medical care, dental care, or mental health providers. They are designated according to geography (i.e., service area), demographics (i.e., low-income population), or institutions (i.e., comprehensive health centers). Jackson and Josephine Counties are both located in a HPSA. The map below depicts these shortage areas relative to the locations of

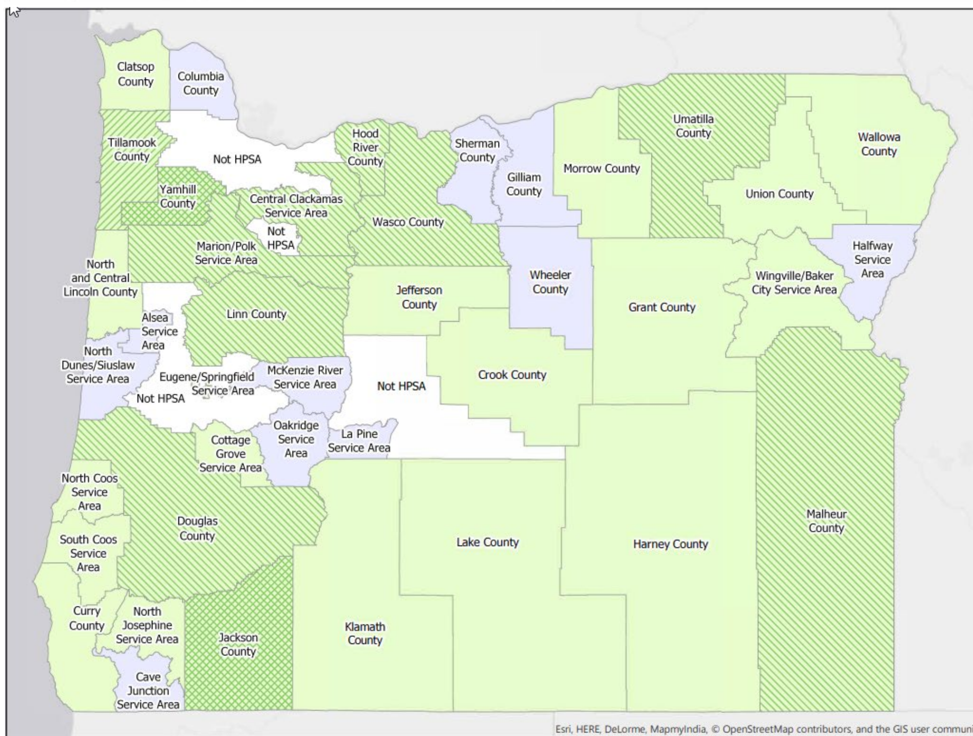
Providence Medford Medical Center and Asante Three Rivers Medical Center, Rogue Regional Medical Center, and Ashland Community Hospital.



Dec 2020 Oregon Dental Health Health Professional Shortage Areas

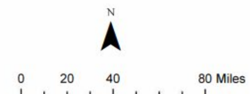
HPSA by Type
- HPSA Geographic
- Low Income
- Low Income/Migrant Farmworker
- Low Income/Migrant Farmworker/Homeless
- Not HPSA

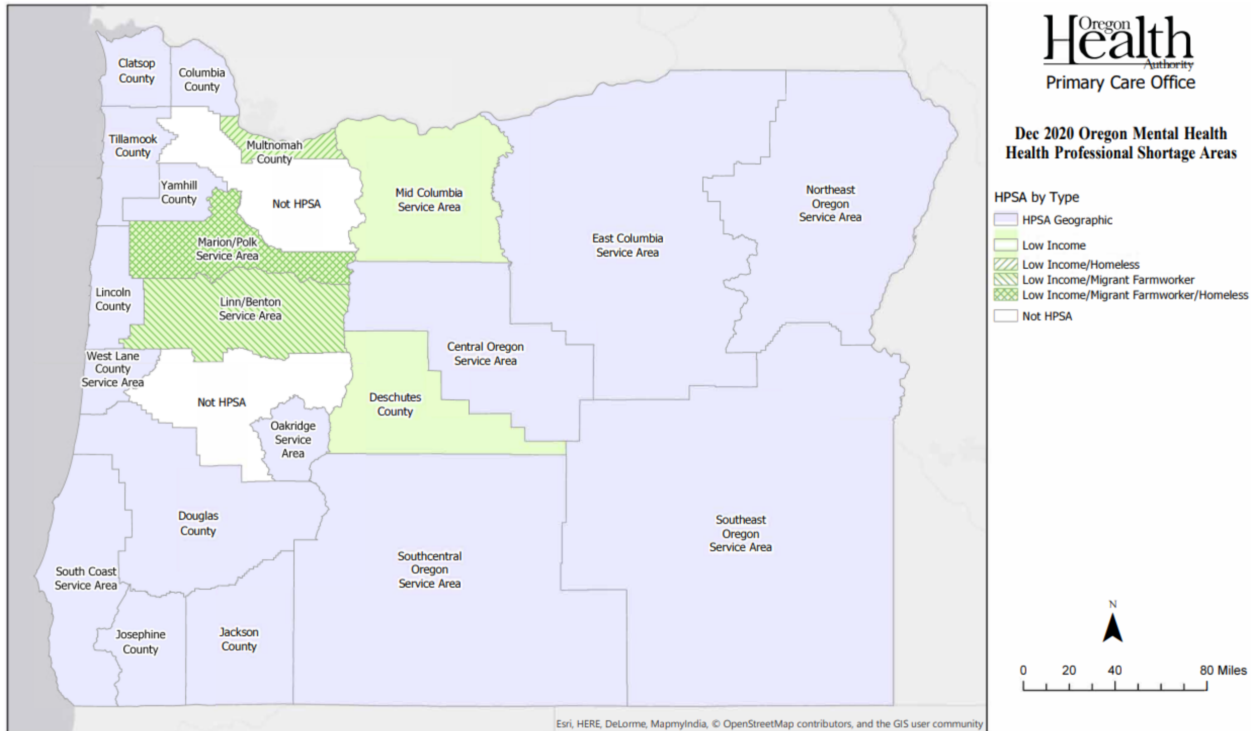




Dec 2020 Oregon Primary Care Health Professional Shortage Areas

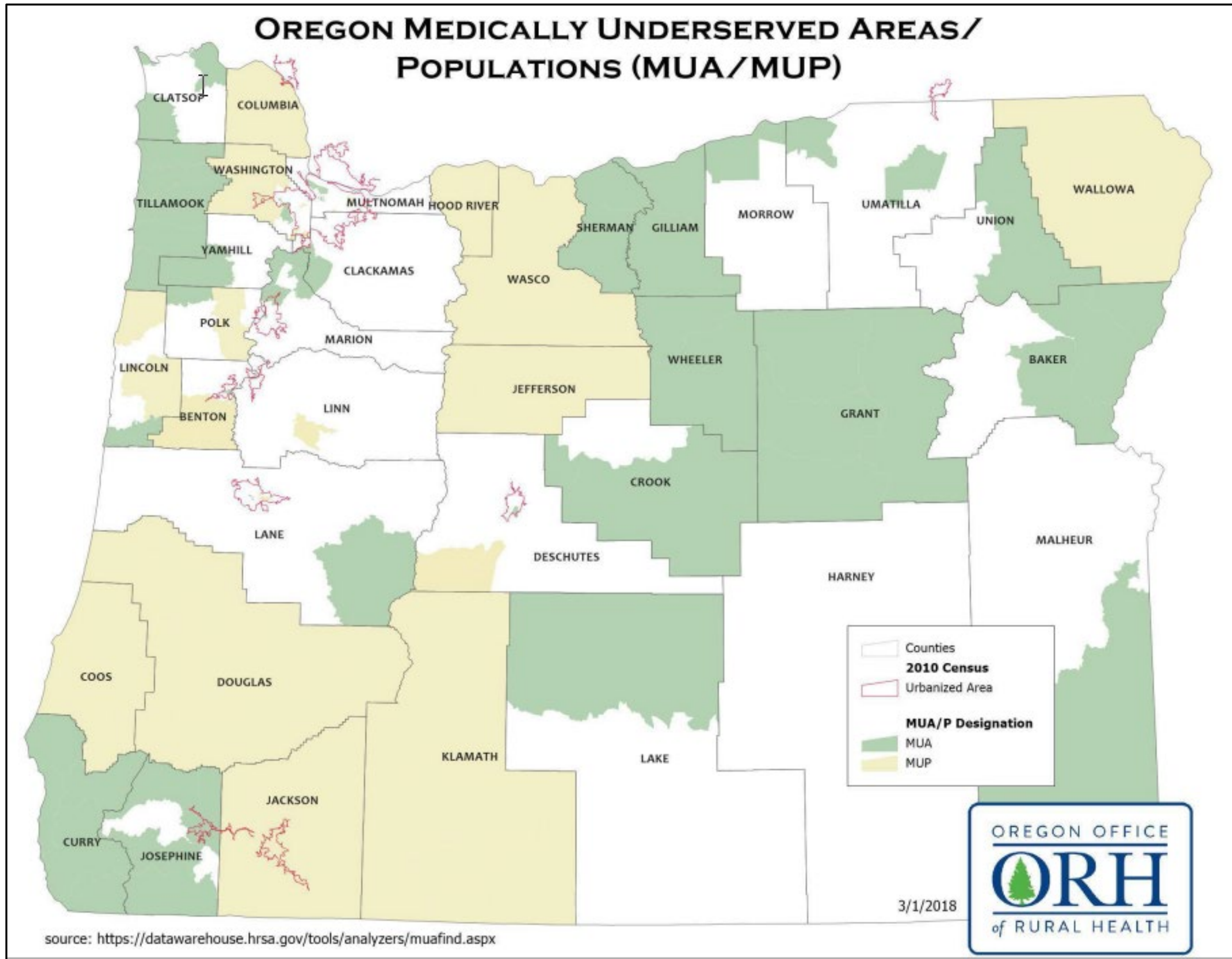
HPSA by Type
- HPSA Geographic
- Low Income
- Low Income/Homeless
- Low Income/Migrant Farmworker
- Low Income/Migrant Farmworker/Homeless
- Not HPSA





MEDICALLY UNDERSERVED AREA/ MEDICAL PROFESSIONAL SHORTAGE AREA

Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs) are defined by the Federal Government to include areas or populations that demonstrate a shortage of health care services. This designation process was originally established to assist the government in allocating the Community Health Center Fund to the areas of greatest need. MUAs are identified by calculating a composite index of need indicators compiled and with national averages to determine an area's level of medical "under service." MUPs are identified based on documentation of unusual local conditions that result in access barriers to medical services. MUAs and MUPs are permanently set and no renewal process is necessary. The following map depicts the MUAs and MUPs in Oregon State.



Appendix 4: Community Resources Available to Address Significant Health Needs

Asante and Providence cannot address all of the significant community health needs by working alone. Improving community health requires collaboration across community stakeholders and with community engagement. Below outlines a list of community resources potentially available to address identified community needs.

Table_Apx 4. Community Resources Available to Address Significant Health Needs

Access to Health Services

Organization or Program Name	Website
AllCare (CCO)	https://www.allcarehealth.com/?locale=en

Care Oregon	https://www.careoregon.org/
Jackson Care Connect (CCO)	https://jacksoncareconnect.org/
Josephine County Health & Human Services	http://www.co.josephine.or.us/Page.asp?NavID=1222
La Clinica	https://laclinicahealth.org/
Rogue Community Health	https://roguecommunityhealth.org/
Rogue Valley Medical Transport (Provides transportation only)	https://myrvmt.com/
Siskiyou Community Health Center	https://siskiyouhealthcenter.com/
Valley Lift (Rogue Valley Transportation District) (Provides transportation only)	https://rvtd.org/accessible-transportation/valley-lift/

Affordable Childcare and Preschools

Organization or Program Name	Website
YMCA	https://rvymca.org/
Kids Unlimited	https://kuaoregon.org/
Boys and Girls Club	https://begreat4kids.com/
Oregon Child Development Coalition	https://www.ocdc.net/locations/#Jackson%20County
Southern Oregon Head Start	https://www.socfc.org/
Southern Oregon Education Services District – Childcare Resource Network	https://www.soesd.k12.or.us/childcare-resource-network/
Family Nurturing Center	https://familynurturingcenter.org/

Southern Oregon Child and Family Council	https://headstartprograms.org/detail/193720_southern_oregon_child_and_family_council_inc_central_point_or.html

Chronic Conditions

Organization or Program Name	Website
AllCare	https://www.allcarehealth.com/?locale=en
Jackson Care Connect	https://jacksoncareconnect.org/
La Clinica	https://laclinicahealth.org/
Oregon Wellness Network	http://www.o4ad.org/oregon-wellness-network.html
Rogue Community Health	https://roguecommunityhealth.org/
Siskiyou Community Health Center	https://siskiyouhealthcenter.com/

Economic Insecurity

Organization or Program Name	Website
ACCESS	https://www.accesshelps.org/
Confident Staffing	https://confidentstaffing.com/
Express Employment Professionals	https://www.expresspros.com/MedfordOR/?utm_source=gmb&utm_medium=organic&utm_campaign=Qiigo
Goodwill Job Connections Centers	https://www.sogoodwill.org/job-connections/

Josephine County Food Bank	https://www.jocofoodbank.org/
Maslow Project	https://www.maslowproject.com/
Oregon Employment Department	https://www.oregon.gov/EMPLOY/Pages/default.aspx
Rogue Retreat	https://www.rogueretreat.org/
St. Vincent de Paul	http://www.stvincentdepaulmedford.info/
United Way	https://unitedwayofjacksoncounty.org/
WorkSource Rogue Valley	https://worksourcerogue.org/

Homelessness and Housing Instability

Organization or Program Name	Website
ACCESS	https://www.accesshelps.org/
City of Grants Pass Housing Advisory Committee	https://www.grantspassoregon.gov/1123/Housing-Advisory-Committee
Hearts With a Mission	https://heartswithamission.org/
Housing Authority of Jackson County	https://hajc.net/
Jackson County Continuum of Care	https://jacksoncountycoc.org/
Jackson County Homeless Task Force	jchtf97501@gmail.com
Josephine County Housing and Community Development Council	https://www.jhcdc.net/
Magdalene Home	https://www.magdalenehome.org/
Maslow Project	https://www.maslowproject.com/

Rogue Retreat	https://www.rogueretreat.org/
United Community Action Network (UCAN)	https://www.ucancap.org/

Mental Health

Organization or Program Name	Website
Adapt	https://adaptoregon.org/
Addictions Recovery Center	https://www.addictionsrecovery.org/
Asante Rogue Regional Medical Center for Behavioral Health Services	https://www.asante.org/Locations/location-detail/behavioral-health-clinic-medford/
Columbia Care Services	http://www.columbiacare.org/index.html
Compass House	https://socompasshouse.org/
Family Solutions	https://familysolutionsoregon.org/
Integrative Health Center at Rogue Community Health	https://roguecommunityhealth.org/integrativehealth/
Jackson County Health & Human Services Crisis Hotline	https://jacksoncountyor.org/hhs/Mental-Health/Crisis-Treatment-Services
Jackson County Mental Health	https://jacksoncountyor.org/hhs/Mental-Health/Welcome
Jackson County Public Health - Syringe Exchange	https://jacksoncountyor.org/hhs/Public-Health/Syringe-Exchange
Kairos	https://www.kairosnw.org/jackson-services
La Clinica	https://laclinicahealth.org/
Maslow Project	https://www.maslowproject.com/

OnTrack Rogue Valley	https://ontrackroguevalley.org/
Options for Southern Oregon - Crisis Resolution Center	http://www.optionsonline.org/crisis-resolution
Rogue Community Health – Integrative Health Center	https://roguecommunityhealth.org/integrativehealth/
Rogue Retreat	https://www.rogueretreat.org/
Southern Oregon Veterans Rehabilitation Center & Clinics	https://www.va.gov/southern-oregon-health-care/health-services/

Substance Use

Organization or Program Name	**Website**
Adapt	https://adaptoregon.org/
Addictions Recovery Center	https://www.addictionsrecovery.org/
Asante Rogue Regional Medical Center for Behavioral Health Services	https://www.asante.org/Locations/location-detail/behavioral-health-clinic-medford/
Columbia Care Services	http://www.columbiacare.org/index.html
Compass House	https://socompasshouse.org/
Family Solutions	https://familysolutionsoregon.org/
Integrative Health Center at Rogue Community Health	https://roguecommunityhealth.org/integrativehealth/
Jackson County Health & Human Services Crisis Hotline	https://jacksoncountyor.org/hhs/Mental-Health/Welcome
Jackson County Public Health - Syringe Exchange	https://jacksoncountyor.org/hhs/Public-Health/Syringe-Exchange

Kairos	https://www.kairosnw.org/jackson-services
La Clinica	https://laclinicahealth.org/
OnTrack	https://ontrackroguevalley.org/
Options for Southern Oregon - Crisis Resolution Center	http://www.optionsonline.org/crisis-resolution
Rogue Community Health	https://roguecommunityhealth.org/
Rogue Retreat	https://www.rogueretreat.org/
Southern Oregon Veterans Rehabilitation Center & Clinics	https://www.va.gov/southern-oregon-health-care/